MHC Healthcare
Quality healthcare with a heart!

Release of Medical Information

I, _____, authorize MHC Healthcare to notify me of upcoming appointments via:

Email: Yes No Phone Call: Yes No Text Message: Yes No

Answering Machine: Yes No Patient/Parent/Guardian's Initials: _____

Disclosures To Individuals Involved In Patient's Care
There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or appointments. Please take a few moments to complete this section.

I authorize MHC Healthcare to disclose my health information that is directly related to my current treatment at MHC Healthcare to the individual(s) listed below for purposes of their role in my treatment for the health services that I have received.

Name:	Relationship:	Patient/Parent/ Guardian's Initials:

I DO NOT wish to have my health information disclosed to the following individuals involved in my care:

Name:	Relationship:	Patient/Parent/ Guardian's Initials:

The above information will assist this office in contacting you with any diagnostic test or procedure results and will be maintained with your medical records. This **Release of Medical Information** form will remain in effect until you notify us of any changes.

_____ _____
Patient Printed Name MHC Healthcare Staff Printed Name

_____ _____
Patient Signature Date MHC Healthcare Staff Signature Date

_____
Signature of Parent/Legal Guardian Date
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied.)

_____
Best Telephone # To Reach The Patient