Christian Health Aid
...sharing makes a difference...

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Medical Information Release Form

Patient information:

Name: _____ Date of Birth: _____ Membership # _____

Release of Information

I hereby authorize Christian Health Aid to disclose any of the following information: Any medical information including assessment, diagnosis, treatment of patient's condition, billing issues, appointment concerns, and medical records.

Please list the name and relationship of the people you wish to have this access.

_____ / _____

_____ / _____

_____ / _____

_____ / _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed _____ Date: _____
(Patient or Responsible Party)