Meadowbrook LTC

Meadowbrook Long Term Care Health Facility
7497 E. John Road Peachtree City, GA 30269
Health Information Phone: 382 749 1188
Health Information Fax: 864 729 6494

Release of Patient Information Consent Form

* Required

Identifying Information

Patient's Name *: Eliot Childeric Phone Number *: 484 775 6199

Physician: Dr. Ranjit Julius

Date of Birth *: 18-Oct-1974 Medical Record #: 2648579943

Date of Treatment: _____

Release To

Name *: Dr. Milena Niklas

Address: 448 Walnutwood Street Danvers, MA 01923

Reason: Specialist

Information to be Released *

☐ Emergency Room ☒ X-Ray ☐ Laboratory ☐ EKG ☐ Transcription

☐ Other: _____

Please Initial *

___ I hereby authorize **Pointe Coupee General Hospital** to furnish the above-named individual or company with all medical data and information they may request, as listed above, concerning my illness or injury. *

___ This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate **1 year** from the date of consent without express revocation. *

___ I hereby consent to the release of any and all records containing **alcohol and/or drug abuse and/or psychiatric diagnosis, sexually transmitted diseases, acquired immunodeficiency syndrome, or human immunodeficiency virus** under the same consideration as outlined above. I understand that such information cannot be released without my specific consent, except in accordance with a court order. *

___ I further understand that I have a right to receive a copy of this authorization upon request. *

Signed

_____ 04-04-1999

Patient, Parent/Legal Guardian * Date *

92 East Gainsway St. Media PA 19063

Address City State Zip Code

_____ RN

Witness Title