Prestige
Medical Group

RELEASE OF CONFIDENTIAL INFORMATION FORM

Patient confidentiality is a priority at Prestige Medical Group.
Therefore, it is important that you provide us with the following information to ensure your privacy.

In the event that I, _____(print your name here), am unable to be reached, Prestige Medical Group has my permission to leave any test results or lab results in the following manner(s) –

Please check all that apply.

☐ Spouse_____

☐ Children – Name(s)_____

May Call or leave message on voicemail at/on:

☐ Home phone:_____
☐ Cell phone:_____
☐ Work phone:_____

☐ Other option/person – Name(s) _____

Complete the information below to authorize release of information

PATIENT NAME:_____

I, _____, **DO NOT** GIVE Prestige Medical Group
(Print Full Name of Person Signing)
permission to release any medical records and billing information.

I, _____, **GIVE** Prestige Medical Group permission to
(Print Full Name of Person Signing)
release medical records and billing information to the following person(s):

Name _____Relationship _____Phone_____

Name _____ Relationship _____Phone_____

Name _____ Relationship _____Phone_____

My Consent will remain in effect as long as I am a patient of Prestige Medical Group unless I notify Prestige Medical Group in writing of any changes. This authorization will remain in effect until a new Authorization is completed.

By signing below, I understand that I have read and understand the privacy practices for Prestige Medical Group. I also understand that I may obtain a copy either by request or by visiting PrestigeMedicalGroup.org.

Signature_____ Date_____