



INFORMATION RELEASE FORM

PATIENT NAME:

DATE OF BIRTH:

ADDRESS:

**I, the undersigned, acknowledge that I have received, read and understand
Charm Medical Supply's Notice of Privacy Practices (HIPAA).**

I hereby authorize Charm Medical Supply to release / obtain prescriptions, letters of medical necessity, growth charts (if applicable) and health insurance information on the above named patient.

To/From:

DR.

MASSHEALTH

OTHER INSURANCE:

For: Company operations and third party payment.

X

Signature of Patient, Parent or Guardian

Relationship to Patient

Date