INFORMATION RELEASE FORM

PATIENT NAME: «PDPatient_First_Nme» «PDPatient_Last_Name»

DATE OF BIRTH: «PDPatient_Birthdate»

ADDRESS: «PDPatient_Street»«PDAddress_Line_2» «PDPatient_City» «PDPatient_State» 0«PDPatient_ZIP_Code»

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. «DRDoctor_Name»

PRIMARY INSURANCE: «PICar_Code» «PICar_Policy_»

SECONDARY INSURANCE: «PICar_Code1» «PICar_Policy_1»

TERTIARY INSURANCE: «PICar_Code2» «PICar_Policy_2»

For: Company operations and third party payment.

X____

Signature of Patient, Parent or Guardian | Relationship to Patient | Date

RETURN THIS COPY- *SIGNED AND DATED*- TO CHARM MEDICAL SUPPLY

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