BlessedCare Center, Inc

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CONSENT FOR RELEASE OF VERBAL CONFIDENTIAL MEDICAL INFORMATION.

I _____ hereby authorize BlessedCare Center to release my healthcare information to:

_____

1. Print name of party authorized to receive information Relationship to patient

_____

Address of party listed above Telephone number of party listed above

_____

2. Print name of party authorized to receive information Relationship to patient

_____

Address of party listed above Telephone number of party listed above

_____

3. Print name of party authorized to receive information Relationship to patient

_____

Address of party listed above Telephone number of party listed above

I authorize the release of my entire medical record via either telephonic or face-to-face Communications to the above named individual (s). Unless otherwise indicated, my authorization Includes the release of the following, please strike through those you wish to exclude, if any:

My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.
My diagnosis and/or treatment regarding mental health issues.
HIV antibody test results and/or AIDS diagnosis and treatment,
Genetic test results and/or related treatment.
Other: _____

I further release and indemnify BlessedCare Center and its affiliates, employees, officers and directors from any and all liability, which in any way results from the disclosure of this information pursuant to the above instruction. This authorization shall remain in effect from the date signed until written revocation is Received. I understand that I am under no obligation to sign this release of information and that it is my Right to inspect all information disclosed, if I so request

_____ _____ _____.

Signature of Patient ID SS#

_____ _____

Date of Birth Date