BooneHealth

Patient Name:
Med Rec Number: Acct Number:
Age: Gender: DOB: Svc Date:

Health Insurance Portability and Accountability Act (HIPAA) - Release of Information

Patient's Name _____ Date of Birth: _____

I authorize my providers at BooneHealth to share information regarding my medical condition and care coordination with the following members of my support system:

Name: _____ Relationship: _____
Phone Number(s): _____ _____

Name: _____ Relationship: _____
Phone Number(s): _____ _____

Name: _____ Relationship: _____
Phone Number(s): _____ _____

Name: _____ Relationship: _____
Phone Number(s): _____ _____

Name: _____ Relationship: _____
Phone Number(s): _____ _____

_____ _____
Patient Signature **Staff Signature**

FORM ID