



CLIENT RELEASE OF INFORMATION FORM

DATE: _____

CLIENT NAME: _____

I hereby give Heritage Corner Health Care Campus permission to release/share personal and medical information to the following for the purpose of planning my care:

➤ _____ Family members.
Please list family member's names _____

➤ _____ Physician's, hospitals, contracting health agencies and any other medical provider deemed necessary for the continuation of my care.

➤ _____ Insurance providers with whom I have policies.

Client or Representative

(Relationship)