Preferred Home Care Services

Medical Release

_____ _____

Consumer Name Date of Birth

_____

Address

_____

City/State/Zip

Subscriber #: _____ Consumer Phone #: _____

I, The above-identified consumer, do hereby authorize the release of my medical records/information to:

Preferred Home Care Services
UMPI # M768403000
612-501-2273
F. 1-888-520-4219

PURPOSE FOR THIS REQUEST:

The purpose of this request related my receiving PCA services through PHCS, now or in the future.

TYPE OF RECORDS REQUESTED:

I hereby request the release of any and all medical records/information that may reasonably pertain to my future or existing need or receipt of PCA services.

AUTHORIZATION VALID FOR:

This authorization is valid for this request and any future services of the kind described herein until I revoke this authorization in writing. This authorization is only valid for PHCS. I understand that I may revoke this authorization by written request at any time by contacting the facility listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that my treatment will not be conditioned on my signing of this authorization. A photocopy of this authorization will be treated in the same manner as the original.

_____ _____

Consumer Signature Date

_____ _____

Responsible Party Date