CMH Physician Services, LLC – Ear, Nose & Throat

A Service of VCU Community Memorial Hospital

RELEASE OF INFORMATION

Patient Name:_____ Date of Birth: _____

This sheet is giving the following persons permission to talk with the doctor or nurse about your medical care and being able to obtain your medical records or bills.
You must be present to add to this list. These individuals must have proof of identification when coming to pick up your information and must know your date of birth when calling in to speak with someone.

Name:

1._____

2._____

3._____

4._____

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PATIENT ACKNOWLEDGEMENT

I have been given a copy of VCU Community Memorial Hospital's Notice of Privacy Practices that describes how my health information is used and disclosed.

_____ _____

Printed Name Signature

_____

Date

If signed by legal representative/guardian, list relationship to the patient

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