COLONIAL MEDCARE, P.C.
2801 BOULEVARD, SUITE B
COLONIAL HEIGHTS, VIRGINIA 23836
(804) 524-0524

CONSENT TO RELEASE OF CONFIDENTIAL HEALTH INFORMATION

We frequently have phone calls from family members inquiring about the health status or treatment of a patient. To protect confidentiality, we ask that you notify us of any family members or others whom you may wish to have your medical information disclosed. If a family member is not listed below, they will NOT be given information regarding your medical care and treatment.

PATIENT NAME: _____

RELEASE INFORMATION TO:

NAME: _____ NAME: _____
RELATION: _____ RELATION: _____
ADDRESS: _____ ADDRESS: _____
_____ _____
PHONE: _____ PHONE: _____

NAME: _____ NAME: _____
RELATION: _____ RELATION: _____
ADDRESS: _____ ADDRESS: _____
_____ _____
PHONE: _____ PHONE: _____

As the person signing this consent, I understand that I am giving my permission to Colonial Medcare P.C. to release my confidential medical information to the individual(s) named above. I also understand that I have the right to revoke this consent but that my revocation will not be effective until delivered to Colonial Medcare P.C. in writing. A copy of this consent shall be included with my original records.

I authorize Colonial Medcare P.C. to disclose any and all information regarding my medical treatment to the individual(s) named above unless such release is otherwise limited as follows:
_____
_____

Colonial Medcare P.C. is ____ is not ____ authorized to leave messages on my home answering machine regarding ____ appointment notification ____ please call office.

This consent shall not expire unless I notify Colonial Medcare P.C. that this consent to release is revoked.

SIGNED: _____ **Date**: _____