Medical Record Disclosure Agreement

SOLVERA HEALTH

Solvera Health values your privacy. Thus, our policy follows the legal aspects of patient confidentiality. In order to discuss medical billing and treatment with anyone besides yourself either in the office or by telephone, we require your written consent.
Please mark the area(s) of your information that you wish to grant access to:

Billing Information: ◯ Yes ◯ No _____ Patient Initials

Medical Information: ◯ Yes ◯ No _____ Patient Initials

Discuss with me only: ☐ _____ Patient Initials

Mark this box if you wish for your information to not be shared with anyone but yourself either in the office or by telephone.

PARTIES ALLOWED ACCESS

Please print the contact information of those with whom you wish to grant access to your information.

1
Full Name:_____ Phone Number:_____
Address:_____ Relationship to Patient:_____
City:_____ State:_____ ZIP:_____

2
Full Name:_____ Phone Number:_____
Address:_____ Relationship to Patient:_____
City:_____ State:_____ ZIP:_____

3
Full Name:_____ Phone Number:_____
Address:_____ Relationship to Patient:_____
City:_____ State:_____ ZIP:_____

4
Full Name:_____ Phone Number:_____
Address:_____ Relationship to Patient:_____
City:_____ State:_____ ZIP:_____

I authorize Solvera Health to discuss my information with the above named person(s). It is my responsibility to inform Solvera Health of any changes to this medical records disclosure agreement.

5
_____ _____
Patient Name Date of Birth

_____ _____
Patient or Partner in Health SIGNATURE DATE

SOLVERA HEALTH STAFF REVIEWED BY _____ DATE APPROVED _____