PREMIER HEALTH, S.C.

PATIENT CONSENT FOR RELEASE OF INFORMATION

1. _____ _____
Name, Last, First, MI Date of Birth

_____
Street Address, City, State and Zip

2. Release records from:

_____
Name

_____
Street Address

_____
City, State and Zip

Release records to:

Dr. Ifueko B. Okundaye
1540 Lyon Drive
Neenah, WI 54956
920-727-4946

3. Type of Information to be Released: (check all applicable categories)

_____ Office notes, prescriptions
_____ X-ray
_____ Operative Reports
_____ Discharge/History and Physical
_____ Emergency Room Reports
_____ Other reports
_____ Immunizations
_____ Laboratory
_____ Consulations
_____ HIV test results
_____ Mental Health Results
_____ Alcohol/Drug abuse

4. This authorization covers patient care given from _____ to _____

5. This information is being released for the purpose of:

_____

This information is valid for 120 days from the date of signature.
The patient can revoke this authorization at any time by notifying us in writing.

The patient agrees that a photocopy of this authorization may be considered a valid authorization. Yes_____ NO _____

_____ _____
Signature of patient or legal guardian **Date**

PDF created with pdfFactory trial version www.pdffactory.com