Sheikh Medical Care PLLC

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RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: _____

BY SIGNING BELOW, I AUTHORIZE (PRACTICE NAME) TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			NAME OF DESIGNATED PERSON
PARENTS	○ YES	◉ No	_____
CHILDREN	○ YES	◉ No	_____
CAREGIVER	○ YES	◉ No	_____
SPOUSE	○ YES	◉ No	_____
IN-LAWS	○ YES	◉ No	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

We always ask that if you have any alternation in this request, so kindly inform the receptionist about it.

(PRACTICE NAME) CAN LEAVE ALL THE APPOINTMENT INFORMATION DIRECTLY ON MY VOICEMAIL:

HOME	○ YES	◉ No
WORK	○ YES	◉ No
RELATIVE	◉ YES	○ No

PATIENT SIGNATURE _____

I AUTHORIZE THE FOLLOWING CONNECTIONS OF PATIENTS TO PICK UP X-RAYS, PRESCRIPTIONS, ETC.

RELATIONSHIP			
SPOUSE	○ YES	◉ No	_____
RELATIVE	○ YES	◉ No	_____
CAREGIVER	○ YES	◉ No	_____

PATIENT SIGNATURE _____ DATE _____

I COMPLETELY UNDERSTAND THAT (PRACTICAL NAME) WILL OFTEN ASK FOR THE IDENTIFICATION OF THAT SPECIFIC PERSON WHO IS PICKING UP PATIENT PRODUCTS OR MEDICAL INFORMATION.