Margolin, Keinarth & Alberda, M.D.
Family Health Center

Consent to Release Medical Information

Consent

I give my consent for **Margolin, Keinarth & Alberda, M.D.** to discuss patient's medical care and payment for medical care with the following people:

Name: _____ Relationship to patient: _____ Phone # _____

Name: _____ Relationship to patient: _____ Phone # _____

Name: _____ Relationship to patient: _____ Phone # _____

PATIENT'S READ AND SIGN AGREEMENT

1 - I hereby give my consent for the physicians of **Margolin, Keinarth & Alberda, M.D.** to evaluate and treat the above patient.
2 - I have been provided with the **Privacy Practices Notice for Margolin, Keinarth & Alberda, M.D.**
3 - I understand that my personal health information will be used for the purpose of treatment, payment and the coordination of health care needs of the patient.
4 - I have also been provided and agree with the **Financial Policy for Margolin, Keinarth & Alberda, M.D.**

Responsible Party Signature	Relationship	Date