Highlands Healthcare

Medical Record Form

Please list the numbers we can call if we need to leave you a message regarding your appointment:

Phone #'s: _____

_____

Is it okay to leave a voicemail regarding your appointment times (please circle one)?

Yes **No**

Please list below any person or persons you would like to designate to be able to request your medical records or pick up your records as needed for appointments, etc. and to discuss your billing information with the billing office.

I give permission to discuss details of my visit and billing information or release my records as needed to the following people.

Note: Your referring/treating physician WILL receive a copy of your medical reports.

Person(s) **Relationship**

1._____

2._____

Signature of Patient:_____**Date:**_____

Witness Signature:_____**Date:**_____

Note: This will remain in effect until it is revoked in writing by the patient