Authorization to Release Medical/Billing Information

I authorize Anchor Bay Family Medical Center to release my medical, billing and testing information to the following individuals:

Name: _____ Phone:_____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

☐ **My information is not to be released to anyone**

☒ **Signature**: _____ **Date**: _____

Notice of Privacy Practices

I understand the offices' Privacy Practices. I am aware it is my right, to request of copy of these practices at any time. I am aware that there's also a copy of the offices' "Privacy Practices" in the waiting room for my review.

☒ **Signature:** _____ **Date**: _____

Consent to Treat a MINOR

I authorize the person/s below, to bring child to Anchor Bay Family Medical to be seen by any physician. I authorize the person/s named below to make necessary medical decisions if needed, in my place, if I'm unable to be present.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

* ☐ My child is of legal driving age. In the event I am unable to accompany him/her to their appointment, I authorize the physicians at Anchor Bay Family Medical to provide all necessary medical care without myself or guardian present.

☒ **Signature: _____ Relationship: _____ Date: _____**