AUTHORIZATION TO RELEASE INFORMATION FROM FAITH COMMUNITY HEALTH RECORD TO THIRD PARTY

Print Client's Name: _____

Daytime Phone Number: _____

I, _____ **do hereby authorize**

Name of Client or Legal Guardian

_____ **to release to** _____

Name of Faith Community Nurse *Name of Third Party*

the following information:

concerning the care I received from the faith community nurse from

_____ **to** _____.

beginning date *ending date*

I understand that I may revoke this consent at any time in writing.

_____ _____

Client Signature *Date*

_____ _____

Witness Signature *Date*

AUTHORIZATION FOR RELEASE OF MEDICAL TO FAITH COMMUNITY NURSE

I, _____, authorize _____

(Name of client/faith community member) *(Name of physician/health provider)*

to allow _____, a faith community nurse with my faith community,

(Name of Faith Community Nurse)

_____, to have access to my private health

(Name of faith community)

information in the following situations. Check all those that apply:

_____ I grant the faith community nurse access to my medical record.

_____ I grant the faith community nurse permission to speak with the physician or other health provider named above about my health condition.

_____ I request the faith community nurse to accompany me to an appointment with the physician or other health provider named above regarding my condition.

_____ _____

Client Signature *Date*

_____ _____

Witness Signature *Date*