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Board Certified Rheumatologists Providing Comprehensive Rheumatologic Care and Osteoporosis Evaluation

Patient Name _____ **Account #:** _____

**RELEASE OF MEDICAL AND BILLING INFORMATION
(Complete this form if you wish to allow family or others access to
your medical and billing information)**

I, _____ do hereby authorize personnel to release information concerning any and all diagnostic studies and findings contained within my clinic chart (whether performed here or elsewhere), my billing, insurance or other account information to the family member(s)/parties listed below:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

X Patient signature: _____ **Date:** _____

Please note: This form is valid from the date signed until another form is requested by the patient.

X: MedRecords/Release of Med and Billing Info