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Corp. Office: 6971 Business Park Blvd. North, Jacksonville FL- 32256; PH: 904-880- 9900 / PH. 904-503-1042
Cell: 904-716-9772; Fax: 904-880-3241
Email : info@prismhealthservices.net ; Website: www.prismhealthservices.net

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Client Records Release Consent Form

CLIENT INFORMATION

Client Name: ____

Address: ____

Phone: (Home)_________________________; (Cell)_______________________________

POWER OF ATTORNEY (POA)

(If applicable: Please provide a copy of the document)

POA Name: ___________________________Relationship to Client: ______________________

Phone: (Home)_________________________; (Cell)_______________________________

Best Time to Call: _________________Email:_______________________________________

REASON FOR CONSENT

I authorize Prism Health Services to release my medical / other records as warranted - related to: (Please check all that apply)

- ☐ Insurance

- ☐ Medical Provider
- ☐ Wellness Provider.
- ☐ Admissions Intake to an institution
- ☐ Legal Matters

- ☐ Governmental Agency
- ☐ Other Reasons: (Please Specify): ___________________________________

- ☐ Family Members / Neighbors Friends (Limited to the following list):
  - ☐ ________________________
  - ☐ ________________________
  - ☐ ________________________
  - ☐ ________________________
  - ☐ ________________________
  - ☐ ________________________

Other: (Specify)__________________________

CONSENT

I consent to the release of my protected health information (PHI) to the above institutions / personnel / persons as needed. This is to protect and maintain the privacy of my PHI with my current health care provider listed above.

________________________ ________________________ ______

Client / Representative Signature | Client / Representative Name | Date