Reliance Health Systems

Authorization of Co-Participation of Care

Patient Name: _____ **DOB:** _____

I authorize Reliance Health Systems to share information regarding my health care with the following people (leave blank if there is nobody you wish to participate in your care). If I want to revoke my co-participation of care with any of the below people I will contact Reliance Health Systems verbally or in writing to notify them of this change.

Name: _____ **Relation:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **Phone:** _____

Please select the information you authorize to be shared with the people you have listed *(Check all that apply)*:

- ❑ Healthcare information
- ❑ Laboratory Results
- ❑ Radiology and Imaging Reports (X-Ray, MRI, CT Scan, etc.)
- ❑ Appointment Information
- ❑ Account Information (Billing)
- ❑ Insurance/Reimbursement
- ❑ Other: _____

Your signature below indicated your agreement to the above policy and all of the conditions herein.

Patient Signature: _____ **Date:** _____

Cilck to Clear

Click to Submit