PREMIER HEALTH, S.C.

PATIENT CONSENT FOR RELEASE OF INFORMATION

_____ _____
Name: Last, First, MI DOB

_____
Street Address, City, State, Zip

Release records from:

Name: _____

Address: _____

City, State, Zip: _____

_____

Release records to:

Okundaye, Ifueko M.D.
1540 Lyon Drive
Neenah, WI 54956
Phone: (920) 727-4946
Fax: (920) 727-4956

Type of information to be released (check all applicable categories):

____ Office notes, prescriptions
____ X-ray
____ Operative Reports
____ Discharge / History & Physical
____ Emergency Room Reports
____ Other reports

____ Immunizations
____ Laboratory
____ Consultations
____ HIV test results
____ Mental health results
____ Alcohol / Drug Abuse

This authorization covers patient care given from _____ to _____

This information is being released for the purpose of:

_____

The patient can revoke this authorization at any time by notifying us in writing.
The patient agrees that a photocopy of this authorization may be considered a valid authorization:
Yes _____ No _____

_____ _____
Signature of patient or legal guardian **Date**