



Acct# _____

CUSTOMER AUTHORIZATION FORM Authorization to Release Information

Many of our customers allow family members and/or friends such as a spouse, significant other, parents, children and/or a caregiver to call and request information about the services that are being or have been provided to and/or financial information related to the account. Under the requirements of HIPAA, we need the customer's consent to release information.

I indefinitely authorize Alick's Home Medical Equipment, Inc. (Alick's) to release my records and all information requested to the following individuals:

Name: _____ Relation to Customer: _____

Phone Number: _____

Name: _____ Relation to Customer: _____

Phone Number: _____

Name: _____ Relation to Customer: _____

Phone Number: _____

Authorization Regarding Messages (please check all that apply)

I authorize you to leave a detailed message on my home and/or cell number regarding order status, questions, concerns and/or financial information.

I authorize you to leave a message with anyone who answers the phone.

Messages may only be left with _____.

I hereby do NOT authorize detailed information to be disclosed through voicemail, any electronic device and/or to any individual.

Patient/Responsible Party – signature

Patient/Responsible Party – please print

Date

Responsible Party's Relationship to Patient