Grandview Health Partners, Ltd.

MEDICAL RECORDS RELEASE

I understand that release of my medical records by this written authorization will result in disclosure of my medical records.

I hereby consent to the release of my medical records to authorized representatives of Grandview Health Partners, Ltd. for appropriate review and/or dissemination of any information pertaining to my condition if requested by myself, my insurance company, attorney, or other related party.

By executing this form I release, discharge and hold harmless Grandview Health Partners, Ltd., its directors, officers, staff, employees, agents, representatives, and assignees from any and all claims, demands, actions, fees and causes of action, suits at law, proceedings in equity, and any liability that may arise by reason of the disclosure of my medical records as authorized herein by me.

_____ _____

Printed Signature Date

CONSENT TO TREAT A MINOR

I hereby consent and authorize Grandview Health Partners, Ltd., or its authorized representatives to administer treatment as deemed necessary to my son/daughter and to the release of his/her medical records.

_____ _____

Child's Name Child's Age

_____ _____

Parent or Guardian's Name Social Security Number

_____ _____

Parent or Guardian's Signature Date