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RELEASE OF INFORMATION & PASSWORD

According to the Federal Government and the Privacy Act, this form will protect your private information from being given to anyone without prior permission.

Please provide us with a password that no one else will be able to identify. This password will give us security when contacting you or you contacting us for health or financial information. Please choose one of the following questions and provide us with an answer.

Thank you!

1) What is your mother's maiden name? _____

2) What street did you live on as a child? _____

3) What was the first car you owned? _____

_____ - - - - -
Print Patient Name: Social Security #

_____ / ____ / ____
Patient Signature: Date:

I hereby authorize the following person(s) to access any and all health information regarding my account. For example, this would include anyone such as a spouse or children. They will have to present the appropriate ID or know your password to obtain any information. Please list individuals below:

IF YOU CHOOSE NOT TO LIST ANYONE THEY WILL NOT BE ABLE TO OBTAIN ANY INFORMATION WITHOUT YOUR WRITTEN CONSENT