Arlington Family Health Pavilion
707 N. Fielder Rd, Suite A
Arlington, TX 76012
Office: 817-277-2671
Fax: 817-460-3004

Authorization for Release/Disclose Financial History

Patient Name:_____

D.O.B_____/_____/_____

Address:_____

City:_____State:_____Zip_____

Home Phone:_____Cell:_____

Date Records Requested:_____/_____/_____

I, authorize Arlington Family Health Pavilion to release my financial history to:

□Self

□Other Authorized Person: _____
(Print Name)

Notes: *(Please included specific dates and/or specific type of financial report needed)*

_____

_____

_____

Information is to be provided by:

□ Hand given in office

□ Fax: _____
(Fax Number)

□ Email: _____
(Email Address)

Patient Signature:

_____

Print Patients Name | Patient Signature | Date

_____

Signature of Patient Representative | Relationship of Patient

(Required patient is a minor or an adult who is unable to sign form)