

Guarantor's Agreement

Date: _____

I give permission for Primary Care Partners to add the following individual to my account:

Name: _____

DOB: _____

I acknowledge that they are 18 years of age or older and considered an "adult". I accept financial responsibility for all charges incurred by this individual while on this account.

Signature _____

Printed Name _____

Address _____

Telephone _____

Relationship to patient _____

Acct # _____

Patient's Consent to Release Medical Information

Date: _____

I give permission for Primary Care Partners to share my personal medical information with the following individuals.

Name(s) & Relationship: _____

Signature _____

Printed Name _____

DOB: _____ SS# _____

Address _____

Telephone _____

Acct # _____