To Whom It May Concern:

We are reaching out to you on behalf of Triad Care, your health and wellness provider. In order to maximize the health coaching program visits, our providers would like to collaborate with your physician to better meet your needs.

We have attached a Patient Release Form. We are requesting that you please fill this out in order to obtain a better understanding of your health. It simply allows us to obtain vital health information from your physician to allow our providers to better serve your healthcare needs as a team.

We have also attached a Patient Medication List. Please complete this form with as much detail as possible. This will allow our providers to have a more precise synopsis of your health. This information will enable both you and your provider to develop a personalized health and wellness plan to fit your individual needs.

If you consent to allow us to obtain your health information from your physician, please fill out the form attached.

If you have any questions, please call:

* Lindsey King at 336-541-6475 ext. 111

We appreciate your time and cooperation with our request and look forward to continuing to work with you as you meet your healthcare goals. Please do not hesitate to call us with any questions or concerns.

Sincerely,

Triad Care, Inc
302 Pomona Drive
Suite L
Greensboro, NC 27407
Phone: 336-541-6475
Fax: 336-541-6485

By signing this release form you are giving permission to release on-going health information automatically to Triad Care Inc.

Release Information From:

Practice Name: ____

Phone: ____

Fax: ____

Patient Information

Patient Name: ____________________________ DOB: ____________________

Street Mailing Address: ____

City, State, Zip: ____

Information to be released:

- ☐ Lab Data
- ☐ Current Medication List
- ☐ Office Visit Notes
- ☐ Other: ____

Release Information To:

Triad Care Inc.
302 Pomona Drive
Greensboro, NC
Phone: 336-541-6475
Fax 336-541-6485

Patient's Rights and Signature:

- *I have the right to revoke this authorization at any time.*
- *I may inspect or copy the protected health information to be disclosed as described in this document.*
- *Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.*
- *Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*
- *I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.*

Print Name: ____

Signature: ______________________________ Date: ____________________

TRIAD CARE
Health Care That Saves

Personal Medication List

Name: ____

DOB: ____

Drug Allergies: ____

Primary Doctor : ____

MD Phone Number: ____

Pharmacy Name & Number: ____

Medication Name	Purpose	Dose/time of day	Form (liquid, tablet,capsule)

Brief Medical History (Acute, Chronic conditions):

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