Adult Medical Information and Treatment Release Form

Patient Name:_____ DOB:_____

My medical information may be released to:

____Spouse _____

____Child/Children _____

____Other_____

____Parent(s)_____

___I authorize messages regarding my medical care to be left on any phone number that I have provided.

___I authorize the release of information including the diagnosis, records, claims information, and examination rendered to me.

This release of information will remain in effect until terminated by me in writing.

By signing below I am confirming that I am the patient, legal guardian, or POA of the above named patient.

_____

Printed Name and Signature: Date: