

Medical Information Release Form

Patient Name:	Date of Birth://
Release of	<u>Information</u>
[] I authorize the release of information examination rendered to me and claims info This information may be released to:	
[] Spouse	
[] Child(ren	
[] Other	
[] Information is not to be released to a	nyone.
This Release of information will remain in ef	fect until terminated by me in writing.
Mess	sages
Please call [] my home [] my work [] m	ny cell
If unable to reach me:	
[] you may leave a detailed m [] please leave a message as [] Other	king me to return your call
The best time to reach me is (day)	time
Signature:	/_Date://
Witness:	Date: / /