Authorization to Release Patient Health Information

Do you authorize medical information regarding your diagnoses, test results, appointments, billing information, etc. to be share with someone other than yourself?

____ Yes   ____ No

Name: _____ Relationship:_____

Phone Number: _____

Name: _____ Relationship:_____

Phone Number: _____

Name: _____ Relationship:_____

Phone Number: _____

Name: _____ Relationship:_____

Phone Number: _____

Name: _____ Relationship:_____

Phone Number: _____

Patient Name: _____ DOB: _____

Signature: _____ Date: _____