Patient Name: Date of Birth:

|  |  |
| --- | --- |
|  | **Medical Information Release Form** |

PSR-16

I authorize the release of information including diagnosis, records, examination rendered and claims information to:

Spouse:

Child / Children:

Other:

 Information may NOT be released to others.

**My Instructions for Message Notification**

Please call: my home my work my cell phone

If unable to reach me:

You may leave a detailed message on my answering machine.

Please only leave a message asking me to return your call.



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

Signature: Date: