

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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: \_\_\_\_\_