

Medical Information Release Form

Patient Name:	Date of Birth://
Release of Ir	<u>nformation</u>
[] I authorize the release of information in examination rendered to me and claims information may be released to:	
[] Spouse	
[] Child(ren	
[] Other	
[] Information is not to be released to any	yone.
This Release of information will remain in effe	ect until terminated by me in writing.
Messa	ages
Please call [] my home [] my work [] my	v cell
If unable to reach me:	
[] you may leave a detailed me[] please leave a message ask[] Other	ing me to return your call
The best time to reach me is (day)	time
Signature:	/Date://
Witness:	Date: / /