AUTHORIZATION TO RELEASE INFORMATION

Name of Patient ____________ Date of Birth ____________ Home # ____________

Cell # ____________

Work # ____________

Address, City, State and Zip Code ____________

The undersigned authorizes information concerning my health information including physical findings, treatment, laboratory tests/results, x-rays, diagnostic studies be released to the following individuals (s) (**other than my current Primary Care Physician**):

Name	Relationship	Telephone

Please check YES or NO if our office can leave appointment reminders, messages, etc. on the following:

YES ☐ NO ☐ Home Answering Machine/Cell Phone Voicemail

YES ☐ NO ☐ Office Voicemail

Signature of Patient/Legal Guardian ____________ **Relationship** ____________ **Date** ____________

Signature of Witness ____________ **Date** ____________

***I Understand that my records are protected by* Federal *and* State *Confidentiality Regulation and cannot be disclosed without my written consent unless otherwise provided for in the regulations.* I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Provider.**