CONSENT TO SHARE MEDICAL INFORMATION

PATIENT NAME: ____

PATIENT DATE OF BIRTH: _________/__________/______________

[ ] I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING THE DIAGNOISIS, MEDICATION, APPOINTMENT INFORMATION AND CLAIMS INFORMATION.

THIS INFORMATION MAY BE RELEASED TO:

[ ] SPOUSE/PARTNER________________________________ PHONE: ______-______-_______

[ ] CHILD(REN) ______________________________________ PHONE: ______-______-_______

______________________________________ PHONE: ______-______-_______

______________________________________ PHONE: ______-______-_______

[ ] OTHER ______________________________________ PHONE: ______-______-_______

[ ] INFORMATION IS NOT TO BE RELEASED TO ANYONE.

THIS MEDICAL INFORMATION RELEASE FORM WILL EXPIRE ONE YEAR FROM DATE BELOW

PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE: ________________________________

DATE: ____________________________