# PATIENT RELEASE OF INFORMATION

I _____ , give permission to the following
(please print name)
people to be able to discuss my medical history and appointment information:

| Name | Phone # | Relationship |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**OR**

☐ Declined - Do not speak to anyone about my appointments, medical care or billing.

Signature of patient: _____Date: _____

Signature of office staff: _____Date: _____

**AUTHORIZATIONS SIGNED BY A LEGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR POWER OF ATTORNEY.**