

## **Medical Information Release Form**

Patient Name:	Date of Birth://
Release of Inf	ormation
[ ] I authorize the release of information inc examination rendered to me and claims inform This information may be released to:	
[ ] Spouse	
[ ] Child(ren	
[ ] Other	
[ ] Information is not to be released to anyo	one.
This Release of information will remain in effect	t until terminated by me in writing.
Messag	<u>les</u>
Please call [] my home [] my work [] my o	cell
If unable to reach me:	
<ul><li>[ ] you may leave a detailed mes</li><li>[ ] please leave a message askir</li><li>[ ] Other</li></ul>	ng me to return your call
The best time to reach me is (day)	time
Signature:	Date://
Witness:	Date: / /