Patient Name: _____ **DOB:** _____ **MRN:** _____

AUTHORIZATION TO RELEASE INFORMATION

I consent to the verbal release of information about my health with the people listed below. This may include any information about my health status, including my condition, symptoms, test results, medications, billing, and scheduling.

Contact Name: _____

Relationship to patient: _____

Phone Number: _____

Check this box to make this your emergency contact ☐

Contact Name: _____

Relationship to patient: _____

Phone Number: _____

Check this box to make this your emergency contact ☐

I understand this authorization will remain in effect until revoked by me in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information have acted in reliance on this authorization.

_____ _____

Signature of Patient / or Personal Representative Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____ _____

Name of Personal Representative Relationship to Patient

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

_____ _____

Reader/Translator Signature Date

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Please return completed form to the appropriate physician's office.