Patient Name: __________________________       Date of Birth: ___/___/____

**Release of Information**

( ) I authorize the release of information/property which includes: Appointment Schedule, Billing/Claims Information, Materials Pickup and Printed Medical Records Pickup. This information/property may me released to:

**Please list any person(s) other than yourself, and their relationship to you that we may discuss your medical information with:**

Name: __________________________       Relation: __________________________

Name: __________________________       Relation: __________________________

Name: __________________________       Relation: __________________________

Name: __________________________       Relation: __________________________

**Minor by:**

Name: __________________________       Relation: __________________________

Name: __________________________       Relation: __________________________

( ) Information is not to be released to anyone.

This *Release of information* will remain in effect until terminated by me in writing.

**Messages**

**Please call** ☐my home ☐my work ☐my cell **Number** __________________________

If you are unable to reach me:

( ) You may leave a detailed message  ( ) Please leave a message asking me to return your call

**Legal Documents:**

( ) Power of Attorney  ( ) Custody Restraining/Restriction Paperwork

( ) Legal Guardianship  ( ) Other: __________________________

Signed: __________________________       Date: ___/___/____