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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____**DOB**: _____
(Please Print)

I hereby authorize the following individual(s) to have access to all of my health information:

_____ **Relationship:** _____

_____ **Relationship:** _____

_____ **Relationship:** _____

_____ **Relationship:** _____

Can we leave messages on your answering machine which may contain health information? Yes___ No___

This agreement will remain valid until such time that you notify us of a change. We will not divulge any healthcare information without this signed agreement.

Patient Signature: _____ **Date**: _____

Authorization to Release Healthcare Information /cw
05/06/14

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