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Medical Information Release Form for Patients and Medical Personnel

Patient Name: _____

DOB:_____

Address: _____

o I authorize the release of information including prescription, vaccination, consulting, and any other health related information to the following.

o I authorize the release of information of a minor of which I am responsible for medical care.

This information can be released to the following:

i. Spouse: _____

ii. Caregiver: _____

iii. Other: _____

The release of this information will remain until terminated by me in writing.

Signed: _____ Date: _____

Title/Relationship: _____