



Emergency Contact:

Name Relationship to Pt. Phone Number

Were you referred to this office? Y N

If so, by whom? _____

I authorize the release of all medical records to the referring physician and/or to my insurance company should it be requested.
I permit a copy of this authorization to be used in lieu of the original.

Date Signature

❖ I, _____ (the patient), do hereby give my permission to release medical information to:

1. _____ 2. _____
Name of Person Relationship Initials of pt Name of Person Relationship Initials of pt



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