



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I AUTHORIZE THE FOLLOWING PERSONS TO HAVE ACCESS TO MY HEALTHCARE INFORMATION. This includes information about exams, surgery, medications and diagnosis.

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

Signed _____

Witness _____

Print Name _____

Print Name _____

Date: _____

This form will remain in effect until revoked or amended by the Patient.

Revocation/Amendment

Signed _____

Witness _____

Print Name _____

Print Name _____

Date: _____