Authorization to Release Medical Information

Patient Name:_____ DOB:_____

I hereby give my authorization and permission for the following members (other than legal guardian) to speak with any staff member concerning my medical condition, appointment information and to pick up any records, orders or hand written prescriptions:

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do it in writing. I understand that this authorization will expire in two (2) years from the date signed below.

_____	_____
Patient/Legal Guardian Signature	**Date**