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Health Information Release Form

In order to assist you in receiving your health information from our office, please complete this form.

I authorize the persons listed below to have access to any and all of my health information. This office is permitted to share any information with them that is disclosed during office visits.

Persons authorized to receive my information (full name, relationship, and phone number):

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ You may notify me or the parties listed above with any information regarding my treatment including appointment reminders, treatment information or prescriptions as follows:

- ☐ Message on home answering machine
- ☐ Message at work voicemail
- ☐ Message on cell phone

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ Patient Name (print)

_____ Patient Signature

_____ Patient Date of Birth

_____ Today's Date

_____ Signature of Parent/Guardian (if applicable)