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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize my healthcare provider or his staff to release or discuss any and all of my medical information as well as medical insurance coverage to any of the following people:

SPOUSE _____

PARENT(S) _____

GRANDPARENT(S) _____

SIBLING(S)_____

CHILDREN _____

OTHER _____

ANSWERING MACHINE _____

NO ONE _____ I DO NOT AUTHORIZE ANY INFORMATION TO BE RELEASED OR DISCUSSED WITH ANYONE OTHER THAN ME.

*****ANSWERING MACHINE ACKNOWLEDGEMENT*****

I understand that any and all medical Information left on an answering machine could be accessed by any person who has access to the messages left on said answering machine.

Patient Name: _____

Signature:

_____

Date: _____