Authorization to Release Information

Name:		
LAST	FIRST	MI
Birthday:		
	sboro Family Medicine to release n	
imaging results, lab results	s, etc.) to the following individuals: (for example: parents,
siblings, spouse, children,	etc.)	
1. Name:		
Phone:	Phone:Relationship:	
		·
2 Name		
2. Namo		
Phone:	Relations	hip:
I do not authorize i	my information to be released to an	iyone.
	•	•
I understand I may revoke	this authorization at any time upon	written notice. I hereby
	ny person complying with this autho	-
agree to note namicos, an	y person complying with this author	nzadon request.
Print Patient Name:		Date:

If patient is a minor, parent or guardian must sign authorization consent.