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REQUEST FOR RELEASE OF INFORMATION

I, _____, Date of Birth: ____/____/____ or SS# _____-_____-_____

Give my permission to release information from my medical record pertaining to:

_____
(Lab results, outpatient procedures, appointments in this office or other offices, accounting or billing information, etc.)

to_____ my _____
(print full name) (relationship)

for the following period of time ____/____/____ until ____/____/____or_____
(until revoked, permanently)

I understand that by signing this document **only** the person above will have access to this information for the period of time I have specified.

_____ ____/____/____
Signature Date

_____ _____
Signature of Witness Print Name of Witness

(TO STAFF: This document is to be used only for the release of patient information to spouse, family member, significant other. This information entered into the computer system and this sheet is to be filed under the grey sheet until revoked or expired.)