



## Patient Consent of Release Medical Information To Individuals/Family Members

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize the release of information including diagnosis, lab results, treatment plans and health information. This information may be released to:

\_\_\_\_\_  
NAME

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

***Health information and test results of a sensitive nature will ONLY be given directly to the patient.***

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that this authorization will remain in effect for a period of six (6) months from its date of origin unless terminated in writing prior to that date.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Expires on