AUTHORIZATION RELEASE

Patient Name: ____ DOB______________

I, ____ (circle one: Self Parent Guardian)

give my permission for the following person(s) to have any and all access to my medical information including all results from labs and tests, and may pick up prescriptions.

Please list the names of person(s) authorized to share the above information:

Printed Name	Relationship to Patient
Printed Name	Relationship to Patient
Printed Name	Relationship to Patient
Printed Name	Relationship to Patient

If the patient is a minor (under the age of 18 years of age):
The following person(s) have permission to accompany my child(ren) to any and all office visits:

Printed Name	Relationship to Parent
Printed Name	Relationship to Parent
Printed Name	Relationship to Parent
Printed Name	Relationship to Parent

Patient/Guardian Signature | Relationship to Patient | Date