Permission to Release Medical Information
For Ages 18 and Up

(must be completed by all patients age 18 and older)

I, _____, give my permission for the following adult(s):
Adult Patient Name (please print)

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

to obtain my personal health information as needed.

Signed: _____ _____
Date of Birth

Date: _____ (expires 1 year from this date)