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PATIENT CONSENT TO RELEASE MEDICAL RECORDS/LABORATORY TESTS

I authorize the release of medical information to the individual(s) noted below:

1. NAME OF PATIENT –PLEASE PRINT
2. _____

SOCIAL SECURITY NUMBER

_____

3. My lab results may be released to my partner Yes ☐ No ☐
4. Medical information may be released to my past or future treating physician Yes ☐ No☐
5. Physician's Name and Address

_____

_____

_____

6. Medical information/lab results may be released to another person or party(please list).

_____

_____

_____

Preferred Phone # _____
☐ OK to leave voice message at preferred phone

1. NAME OF PARTNER (IF RELEVANT) –PLEASE PRINT
2. _____

SOCIAL SECURITYNUMBER

_____

3. My lab results may be released to my partner Yes ☐ No ☐
4. Medical information may be released to my past or future treating physician Yes ☐ No☐
5. Physician's Name and Address

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6. Medical information/lab results may be released to another person or party (please list).

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Preferred Phone # _____
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SIGNATURE	DATE	SIGNATURE	DATE
WITNESS	DATE	WITNESS	DATE