

Release Form for Individuals Involved in Care of Patient

I, _____ give Brown road Family Medicine permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans, and payment for health services I receive.

This consent is valid until such time as I provide a written revocation of it.

Brown Road Family Medicine may speak with:

Name: _____

Relationship: _____

Information to be released:

Treatment Diagnosis Schedule Payment Other: _____

Name: _____

Relationship: _____

Information to be released:

Treatment Diagnosis Schedule Payment Other: _____

Permission to leave lab and any medical results on voicemail:

Medical Assistant may leave lab results on voicemail

Medical Assistant may not leave lab results on voicemail

Patient Signature: _____ Date of birth: _____

Date Signed: _____

Account Number: _____