Authorization for Release of Medical Information (Adult)

Dr. Anne! Modern Parenting, Classic Healthcare.
www.DrAnneMD.com

Patient Name _____ Date _____

I hereby authorize Anne Georgulas, M.D. and staff or delegated staff to release my medical information. I hereby authorize the following persons to receive my information by verbal or written statement:

Name	Relationship

Please check all that apply, and enter phone numbers:

- ☐ I consent to verbal release of medical information, including phone messages, on my home phone. _____–_____–_____
- ☐ I consent to verbal release of medical information, including phone messages, on the following phone. _____–_____–_____
- ☐ I consent to verbal release of medical information, including phone messages, on the following phone. _____–_____–_____

Signature _____