Release of Medical Information

PERSONAL INFORMATION

Name

Birth Date

Phone Number

Email

MEDICAL HISTORY

Do you use tobacco in any form?

Yes ○ No ○

Are you taking any medication?

Yes ○ No ○

if yes please list

Do you have any allergies?

Yes ○ No ○

if yes please list

Do you have any disease, condition or problem that you feel we should know about? If so, please describe

Authorization

I, _____ _____, hereby authorize the medical care provider to use and store up and release my medical information to facilitate continuity of care and for legal proceedings.

This authorization is effective from the date of signing below and will remain in effect until revoked in writing by me or my legal representative. I know and understand that I have the right to revoke this authorization at any time by providing written notice to the medical care provider.

I undertake that the release of medical information is voluntary, and I am providing this authorization of my own free will. I know and understand that the information disclosed may be protected by federal and state laws governing the privacy of medical records.

Name _____ _____

Date _____

Signature

_____

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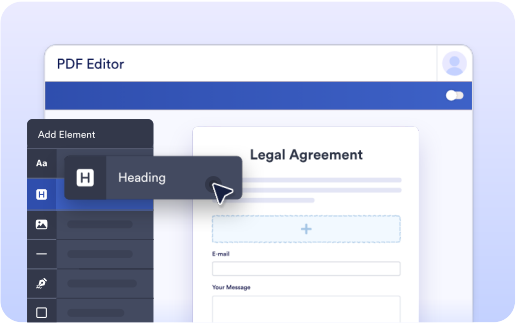

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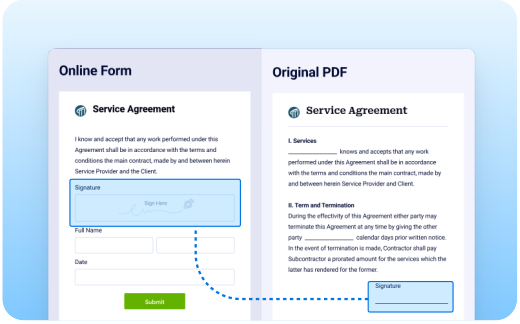

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