Release of Information

PATIENT NAME: _____ **DOB** _____

_____ _____

Parent\Guardian (if minor) Relation

Adults

I hereby authorize Dr. Medi, his associates, and his staff to release my protected health information to the following individuals as well as release the office of any liabilty. I understand that these individuals may contact the office on my behalf to inquire about confidential information in my medical records and future appointments at any given time.

Minors

I hereby authorize Dr. Medi, his associates, and his staff to treat this patient when accompanied by the following person(s). I understand that I am permitting this office to release protected health information to the following individuals for the purpose of medication management and setting up appointments. Furthermore, I take full responsibility for notifying the office in advance with any changes in insurance or contact information and for having the payment at the time of service.

The following person(s) must be over the age of 18.

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

_____ _____

Patient\Guardian Signature Date