PERMISSION FORM TO RELEASE MEDICAL INFORMATION

I _____, hereby grant permission to:
(Patient Printed Name)

_____
(Name of friend, relative, spouse, attorney, etc. granting to receive medical information)

(**Write YES or NO on the items you are granting permission to be released**)

_____ Medical information on my behalf

_____ pick up prescriptions on my behalf

_____ verify appointments on my behalf

_____ receive copies of medical records on my behalf

_____ I authorize permission to leave messages on my voice mail

I am providing my physician a copy of the following documentation to keep in my medical file. (Mark **YES** or **NO** if you have the following documentation)

ADVANCED DIRECTIVES_____
HEALTHPOWER OF ATTORNEY: _____
LIVING WILL: _____

This form will remain in effect until I revoke permission with a written notification.

Effective Date: _____

Signature of Patient: _____

Printed Name of Patient: _____