RED RIVER FAMILY PRACTICE, LLP

Michael E. Killian, MD Cynthia Brinson, MD J. Eric Lambeth, MD
Gary L. Werntz, MD Mary Bartz, MD Steven B. Hutto, MD

CONSENT TO RELEASE PERSONAL MEDICAL INFORMATION

I, _____, give my consent to the Staff and

Physicians of Red River Family Practice to release any medical information

pertaining to me to the following people:

_____	_____	____-____-____
Name (please print)	Relationship	Phone
_____	_____	____-____-____
Name (please print)	Relationship	Phone
_____	_____	____-____-____
Name (please print)	Relationship	Phone
_____	_____	____-____-____
Name (please print)	Relationship	Phone

Please understand that we cannot share any information with your family and friends at any time unless they are listed above.

Patient Name: _____ DOB: _____

Signature: _____Date:_____

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