CONSENT FORM FOR THE
RELEASE OF PATIENT INFORMATION
TO FAMILY MEMBER(S)

I hereby authorize **ESSENTIAL FAMILY MEDICINE, LLC** to furnish medical information requested. This could include my entire medical record which may contain information regarding, alcohol and / or drug abuse and /or psychiatric and / or HIV and /or sickle cell diagnosis.

This consent is subject to revocation by the undersigned at any time except to the extent that action has already been taken upon this consent.

INDIVIDUAL(S) TO WHOM INFORMATION MAY BE RELEASED:
Other than yourself, who may we discuss your treatment, diagnosis, test results, pathology reports, or account information with?

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

IDENTIFYING INFORMATION:

_____ _____
Patient Signature DATE

_____ _____
Print Name Date of Birth

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

_____ Home Phone -- The number is _____

_____ O.K. to leave message with detailed information.
_____ Leave message with call back number only.

_____ Written Communication.

_____ Email Address _____
_____ O. K. to mail to my home address.
_____ O. K. to mail to my work address.

_____ Work Phone – The number is _____

_____ O. K. to leave message with detailed information.
_____ Leave message with call back number only.