Release Form
Authorization to Discuss Medical Information

If you ever need someone to cancel or make an appointment for you, to confirm your prescription, or to make a payment - we need to have their name here - or else we cannot acknowledge you are a patient at this office. If there isn't anyone who would call on your behalf, please enter *no one* in the space below. Please be sure to cross out anytihg you DO NOT want discussed.

I authorize Philip Borgardt M.D., Inc. / TNC, Inc. to discuss my information with*:

Name of friend or family members (printed)	Relationship to patient
______________________________	________________
______________________________	________________
______________________________	________________

(Please cross out anything below you do not wish discussed.)

- Medical conditions
- Appointments
- Prescriptions
- Payments or other issues specified below

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Patient name ____________________________ DOB ____________________
(Please print)

Patient signature ________________________ Date ____________________

* It is your responsibility to inform us of any changes in the future.

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