PERSONAL MEDICAL INFORMATION RELEASE

Patient Name: _____

Date of Birth: _____

Please list the telephone numbers where we can contact you:

	Number	May we leave a message?
1.	_____	yes / no
2.	_____	yes / no
3.	_____	yes / no

You may share my medical information with the following people: (Family, spouse, children, siblings, etc)

	Name	Relationship	Phone #
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

The following people are authorized to pick up a prescription order or samples for me:

	Name	Relationship
1.	_____	_____
2.	_____	_____

_____ _____

Signature Date