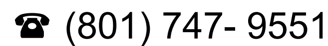
GROVER, MD PSYCHIATRY
Clinic & Counseling Center

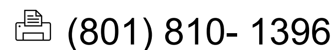
Douglas Grover, MD

322 E Gateway Drive| Suite 102

Heber City, UT 84032

Release of Information





Release of Information

PATIENT FULL NAME **DATE OF BIRTH**

PATIENT HOME ADDRESS **PATIENT PHONE** **EMAIL ADDRESS**

I GIVE DOUGLAS GROVER, MD PERMISSION TO DISCUSS MY MEDICAL AND MENTAL HEALTH HISTORY WITH THE FOLLOWING INDIVIDUALS/INSTITUTIONS (If none, write NONE):

I GIVE THE FOLLOWING INDIVIDUALS/INSTITUTIONS PERMISSION TO RELEASE MY MEDICAL RECORDS TO DOUGLAS GROVER, MD: (If none, write NONE):

By signing your name in the space provided, you are giving Douglas Grover, MD permission to contact the above named individuals/institutions for the purpose of discussing and/or obtaining your mental health history and medical health history. This includes medical records. You understand that this form is valid until you specifically state in writing that you no longer give Douglas Grover, MD permission to do the above.

PATIENT FULL NAME (PRINT) **DATE**

SIGNATURE (REQUIRED) **DATE**