Partners in Family Medicine
6000 24 Mile Road
Shelby Township, MI 48316

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ DOB:_____

I authorize the Partners in Family Medicine to release medical information to the following people:

	Name	Relationship	Phone Number
1.			
2.			
3.			

☐ NONE

I authorize the following people to pick up my prescriptions, results, samples, etc.:

	Name	Relationship	Phone Number
1.			
2.			
3.			

☐ SAME AS ABOVE ☐ NONE

X_____ _____
Patient/Representative Signature Date

_____
Witness