**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient Name: DOB:

I authorize Partners in Family Medicine to send an automated invitation to create a patient portal account. If this email does not belong to me, I authorize PFM to send an email on my behalf to the account listed below which will have access to my medical record.

Preferred email address:

I authorize 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