CONSENT FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth _____

Cell Phone#: _____ Email: _____

Please check the sections that apply, then sign at the bottom of the page:

_____ **I do not give PFP permission** to release my information to anyone other than myself.

or

_____ **I give PFP permission** to release my information that includes:

___ _Entire Medical Record
___ Blood Tests
___ X-rays
___ Cultures, including throat, urine and genital
___ Appointment Details
___ _Billing Information

with

_____ My spouse or significant other (Name _____)
_____ Family member (Name _____)
_____ On home answering machine or cell phone # On _____
_____ Office/work voice mail # _____

I also give permission to receive all information by mail to address:

_____

_____

Signature: _____ Date: _____

(A signature is required for this form to be considered valid)