HELTON
family medicine

T. MICHAEL HELTON, M.D.

AUTHORIZATION TO RELEASE INFORMATION

PATIENT'S NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

___☐___ I authorize this healthcare facility to release medical information (i.e., x-rays results, lab results, etc.) to the following individuals:

1. _____ _____
NAME RELATIONSHIP

2. _____ _____
NAME RELATIONSHIP

___☐___ I do not authorize my information to be released to anyone.

I understand I may revoke this authorization at any time upon written notice. I hereby agree to hold harmless, any person complying with this authorization request.

_____ _____
Patient Signature Witness

_____ _____
DATE DATE