RELEASE OF INFORMATION AUTHORIZATION FORM

Please list below any person(s) such as a spouse, significant other, parent, sister or brother, child, aunt, cousin or friend to whom you authorize the release of information from us regarding you. You may authorize specific types of information that we may release to each individual you identify.

Medical information:
You authorize us to release details regarding your symptoms, diagnosis and treatment.

Accounting:
You authorize us to release details regarding your account and insurance coverage.

Emergency Contact: You would like us to contact this individual in the event of an emergency and you authorize us to release any information we deem necessary to protect your life and or health.

Without your consent, we are not allowed by law to release any information except to you.

Patient Legal Name_____Birthdate_____

Name	Relationship	Medical Info	Accounting	Emergency Contact	Emergency Phone No.

I understand that I have authorized Patricia Roy, D.O. and/or her staff to release information only as listed above. I may revoke any and all authorizations at any time in writing.

_____ _____

Patient or Legal guardian signature Effective Date (Mandatory)