Stonebrook Family Medicine
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CONSENT TO RELEASE MEDICAL INFORMATION TO FAMILY

ALL ITEMS ON THIS AUTHORIZATION MUST BE COMPLETED IN FULL

Patient Name: ____

Date of Birth: ____________________________ Phone: __________________________________

Address: ____

THE INFORMATION IS TO BE RELEASED TO

Name: ________________________________ Name: ________________________________

Relationship: ___________________________ Relationship: ___________________________

Phone: ________________________________ Phone: ________________________________

Name: ________________________________ Name: ________________________________

Relationship: ___________________________ Relationship: ___________________________

Phone: ________________________________ Phone: ________________________________

I, ____________________________________, give my permission for Dr. Chacko and staff to release medical information pertaining to my health.

____ Date ___________________________

Signature of Patient or Representative/Guardian