PERSONAL MEDICAL INFORMATION RELEASE

Patient Name: _____

Date of Birth: _____

Please list the telephone numbers where we can contact you:

Number	May we leave a message?
1 _____	yes / no
2 _____	yes / no
3 _____	yes / no

You may share my medical information with the following people:

Name	Relationship	Phone #
1		
2		
3		

The following people are authorized to pick up a prescription order or samples for me:

Name	Relationship
1	
2	

_____ _____

Signature Date