PATIENT INFORMATION RELEASE FORM

PATIENT NAME:________________________ DATE OF BIRTH:_________________________

(phone # on demographic form will be used, please keep updated)
__ do NOT leave phone messages
__do NOT contact at work
__ only speak with patient
__ YOU MAY leave phone messages
__YOU MAY contact via email

I hereby authorize Family Care Dahlonega to share my personal health information with:

__ NO ONE other than myself and those required by law
__SPOUSE:____
__PARENTS:____
__CHILDREN:____
__FRIEND:____
__OTHER:____

SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE: _________________________________

DATE:_______________