



Permission to Release Medical Information For Ages 18 and Up

(must be completed by all patients age 18 and older)

I, _____, give my permission for the following adult(s):
Adult Patient Name (please print)

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

to obtain my personal health information as needed, including but not limited to: test results, clinical notes, appointment scheduling, etc.

This document will expire 1 year from the date it is signed, and I can revoke my permission at any time.

Check here to give the above adults my permission to access my personal health information through the patient portal.

Signed: _____ Date of Birth _____

Date: _____ (expires 1 year from this date)