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Authorization for Release of Medical Information (Adult)

Patient Name _____ Date _____

I hereby authorize Anne Georgulas, M.D. and staff or delegated staff to release my medical information. I hereby authorize the following persons to receive my information by verbal or written statement:

Name	Relationship

Please check all that apply, and enter phone numbers:

☐ I consent to verbal release of medical information, including phone messages, on my home phone. _____–_____–_____

☐ I consent to verbal release of medical information, including phone messages, on the following phone. _____–_____–_____

☐ I consent to verbal release of medical information, including phone messages, on the following phone. _____–_____–_____

Signature _____