CNPMG

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RELEASE OF INFORMATION

Patient's Name: _____ ***Date of Birth:*** _____

FOR DISCUSSION WITH FAMILY AND/OR FRIENDS

I hereby give authorization to release information and/or discuss my medical condition including my protected health information such as psychological or psychiatric impairment, drug and/or alcohol use/abuse, or Acquired Immunodeficiency Syndrome (AIDS), or tests for infection with Human Immuno-deficiency virus (HIV), with the person(s)/entities listed below:

Person/entity name: _____

Relationship to Patient (or other description) _____

Person/entity name: _____

Relationship to Patient (or other description) _____

Person/entity name: _____

Relationship to Patient (or other description) _____

REQUEST RECORDS FROM THE FOLLOWING

Physicians Name: _____ Phone # _____

Physicians Name: _____ Phone # _____

Physicians Name: _____ Phone # _____

This authorization can be revoked at any time upon my request.

Patients Signature: _____ ***Date:*** _____