NORTHCREST FAMILY MEDICINE

PATIENT INFORMATION RELEASE FORM

Patient Name: _____ **DOB:** _____

Patient Address:

Street: _____

City: _____ **State:** _____ **Zip:** _____

Patient Phone #

Home: _____ **Cell:** _____ **Work:** _____

☐ **I do not want my medical information to be discussed with anyone other than myself.**

☐ **Medical information and/or test results can be given to the following person(s).**

1. Name: _____ Relationship to patient: _____

   Home # _____ Cell #_____

2. Name: _____ Relationship to patient: _____

   Home # _____ Cell #_____

*Leave telephone message on recorder concerning the following (write yes or no):

Prescriptions: _____ Test results: _____ Referrals: _____ Appointments: _____

Patient or Guardian Signature: _____

Date: _____ Office Witness: _____