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AUTHORIZATION TO DESIGNATE RELEASE OF HEALTH INFORMATION

I, _____, authorize the staff and medical providers of
Print Patient Name

Desert Family Medical Center to release and discuss any and all medical
information and healthcare issues about myself to the following:

Check all that apply and complete the blanks:

___ Spouse/Partner Name of Spouse/Partner: _____

___ Relative Name of Relative: _____

Relationship to Patient: _____

___ Parent/Guardian Name of Parent/Guardian: _____

___ Via E-mail Preferred E-mail Address: _____

___ Via Fax Preferred Fax Number: _____

___ Via USPS Mail Preferred Mailing Address: _____

Print Patient Name

Patient Signature

Patient's Date of Birth

Date

*PLEASE NOTE: Patient is responsible for any changes with regard to whom or how they want their information released. Please inform our staff, if you desire any changes in designation of release of your health information. Thank you for your cooperation and understanding of our office policies.

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