RELEASE OF MEDICAL INFORMATION

I, _____, DOB _____, authorize Apple Family Medicine and/or its designees to release medical information upon request of the following parties. I also authorize Apple Family Medicine and/or its designees to leave messages on my voicemail/answering machine regarding test results and appointments.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

I understand that the only information that will be released will be test results, clarification of medications, and appointment information. This does not give the authority for copies of my medical records nor does it allow the above named individuals permission to view my medical records. I understand that I may revoke this authorization at any time in writing.

Signed:

_____ Date: _____

Witness:

_____ Date:_____