

## Release of Medical Information

My Medical Care may be discussed with:

Name: \_\_\_\_\_

Yes

No

DOB: \_\_\_\_\_

Relation: \_\_\_\_\_

Name: \_\_\_\_\_

Yes

No

DOB: \_\_\_\_\_

Relation: \_\_\_\_\_

Athletic Trainer: \_\_\_\_\_ School: \_\_\_\_\_

\*I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance upon the authorization.

Test Results may be left on my answering machine/voice mail.

Yes

No

Appointment information may be left on my answering machine/voicemail.

Yes

No

### **If Applicable, for personal representative:**

Print name of Personal Representative: \_\_\_\_\_

Describe Personal Representative relationship: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

\*Please note we do require documentation for personal representatives.