Apollo Family Medicine
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TEL#: (470) 875-1560
FAX#: (470) 781-2710

Medical Information Release Form

Patient Name: _____ DOB: _____

RELEASE OF INFORMATION:

I hereby authorize the release of my medical information including diagnoses, medical records, examination findings, test results, and insurance claims information to the following:

	Spouse	Name:
	Child(ren)	Name(s):
	Other:	Name(s):
	Information is NOT to be released to anyone.	

This release of information will remain in effect until terminated by me in writing.

MESSAGES:

Please call the following number for any messages from Apollo Family Medicine:

	Home	Number:
	Work	Number:
	Cell	Number:

If unable to reach me:

	You may leave a detailed message.
	Please leave a message asking me to return your call.
	_____.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Name of Patient or Legally Authorized Representative

_____ _____
Signature of Witness Date