

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
TO FAMILY MEMBERS, POWER OF ATTORNEY, ETC.

I, _____ authorize Dr. LaGraize to release any and all information pertaining to my care, including but not limited to, future appointments, treatment plans, prognosis, etc., to the following individuals:

- If permission given, list the name(s) of the individual (s) who will have the authority to receive any & all information pertaining to your care and then sign and date the form.

- IF YOU DO NOT WISH ANY INFORMATION TO BE RELEASED DRAW AN "X" OVER THE TWO SECTIONS LISTED BELOW and then sign and date the form.

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

**Patient
Signature:**

**Printed Name of
Patient:** _____

Date: _____