INSERT PATIENT LABEL HERE

Authorization to Release Medical Information to Family Members

I, ____ authorize Southern Vascular Clinic 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, please list the name(s) of the individual(s) who will have authority to receive any and all information pertaining to your care.
- ❖ If you do not wish to have any information released, please put an "X" over the sections listed below.

Name:____ Relationship:_______________________

Telephone Number: ____

Name:____ Relationship:_______________________

Telephone Number: ____

Name:____ Relationship:_______________________

Telephone Number: ____

Name:____ Relationship:_______________________

Telephone Number: ____

Patient Signature:____ Date:_______________________

Name Printed: ____