



HELTON
family medicine

T. MICHAEL HELTON, M.D.

AUTHORIZATION TO RELEASE INFORMATION

PATIENT'S NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

_____ I authorize this healthcare facility to release medical information (i.e., x-rays results, lab results, etc.) to the following individuals:

- | | | |
|----|------|--------------|
| 1. | | |
| | NAME | RELATIONSHIP |
| 2. | | |
| | NAME | RELATIONSHIP |

_____ I do not authorize my information to be released to anyone.

I understand I may revoke this authorization at any time upon written notice. I hereby agree to hold harmless, any person complying with this authorization request.

Patient Signature

Witness

DATE

DATE