PATIENT INFORMATION RELEASE FORM

PATIENT NAME:____

PATIENT ADDRESS:____

PATIENT TELEPHONE: ____

OK TO LEAVE MESSAGE ON ANSWERING MACHINE / VOICE MAIL
Circle One YES NO

If no, how shall we contact you? ______________________________
Please note: Patient accepts responsibility for contacting Valley Medical Center if you do not wish to have us leave a message on your answering machine/voice mail.

I authorize Valley Medical Center to speak with / release information concerning my medical records / health to the following person(s):

	NAME	
Husband	______________________	Phone ________________
Wife	______________________	Phone ________________
Mother	______________________	Phone ________________
Father	______________________	Phone ________________
Stepmother	______________________	Phone ________________
Stepfather	______________________	Phone ________________
Daughter	______________________	Phone ________________
Daughter	______________________	Phone ________________
Son	______________________	Phone ________________
Son	______________________	Phone ________________
Other	______________________	Phone ________________
Other	______________________	Phone ________________

SIGNATURE______________________ **DATE**________________

This information stands indefinitely unless you notify Valley Medical Center otherwise. 04/14/03