TruCare Internal Medicine & Infectious Diseases

Consent to Release Medical Information

Patient Name: ____________________________

While under the care of TruCare Internal Medicine and Infectious Diseases, you have my permission to release my medical information to the following relatives or acquaintances if needed:

Name	Relationship	Phone
_______________________________	_____________________	( )_______________
_______________________________	_____________________	( )_______________
_______________________________	_____________________	( )_______________
_______________________________	_____________________	( )_______________
_______________________________	_____________________	( )_______________
_______________________________	_____________________	( )_______________
_______________________________	_____________________	( )_______________

Patient signature: ____**Date**: ______________

Witness: ____ **Date**: ______________

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