Release Form for Individuals Involved in Care of Patient

I, _____ give Desert Grove Family Medical permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans, and payment for health services I receive.

This consent is valid until such time as I provide a written revocation of it.

This office may speak with:

Name: _____

Relationship: _____

Information to be released:

☐ Treatment ☐ Diagnosis ☐ Schedule ☐ Payment ☐ Other:_____

Name: _____

Relationship: _____

Information to be released:

☐ Treatment ☐ Diagnosis ☐ Schedule ☐ Payment ☐ Other:_____

Patient Signature: _____

Date: _____

Account #: _____