

**RELEASE OF INFORMATION**

DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

I, \_\_\_\_\_, authorize College Station Family Medicine Center to release my medical records/information that pertains to lab/radiology results and/or treatment to the following people if I am unable to be reached/contacted:

- 1) \_\_\_\_\_ Phone # \_\_\_\_\_
- 2) \_\_\_\_\_ Phone # \_\_\_\_\_
- 3) \_\_\_\_\_ Phone # \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

I, \_\_\_\_\_, authorize College Station Family Medicine Center to leave information on my personal voicemail at the following numbers:

HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE: \_\_\_\_\_