ESSENTIAL
FAMILY HEALTH & WELLNESS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I _____ give permission to ESSENTIAL FAMILY HEALTH & WELLNESS, LLC, to release any information, verbally or written, on my behalf to the following persons.

PLEASE PRINT

NAME _____

Phone: _____ Relationship to Patient: _____

NAME _____

Phone: _____ Relationship to Patient: _____

NAME _____

Phone: _____ Relationship to Patient: _____

NAME _____

Phone: _____ Relationship to Patient: _____

I give permission to leave messages via: ____ Voicemail ____ Patient Portal ____ Email

This notice will expire upon written notice as provided by the patient to ESSENTIAL FAMILY HEALTH & WELLNESS, LLC.

_____ _____

Patient/Guardian Signature Date

_____

Print Patient Name