SAGE Family Medicine Associates, PA
Kevin L. Uptergrove, M.D.
David C. White, M.D.
Erika B. Garcia, M.D.
Mary Elizabeth Andres, BSN, FNP-BC
Suzanne Rue, MSN, FNP-C

Release Consent

Date:_____

I, _____give permission to Sage Family Medicine Associates, PA to
Patient Name

release any medical information to _____(Name),

_____(relationship); until further notice.

Consent is only valid for one year **Consent Expires**: _____

_____ _____/_____/_____
Signature of Patient ***Date***

_____ _____
Name of Patient ***Telephone Number***

_____
Mailing Address/City, State/Zip Code

_____ _____/_____/_____
Signature of Witness ***Date***

_____ _____/_____/_____
Signature of Witness ***Date***