CONSENT TO RELEASE PERSONAL MEDICAL INFORMATION

I, _____, give my consent to the Staff and Physicians with Red River Family Practice to release medical information pertaining to me to the following people:

_____

Name (please print)

_____

Name (please print)

I understand that without this form, Red River Family Practice will not release any information pertaining to me to any person other than myself as required by law.

_____ _____ _____

Patient Signature ***Date of Birth*** ***Date***