RED RIVER FAMILY PRACTICE, LLP

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CONSENT TO RELEASE PERSONAL MEDICAL INFORMATION

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

______________________________	____________	_____-_____-_____
Name (please print)	***Relationship***	***Phone***
______________________________	____________	_____-_____-_____
Name (please print)	***Relationship***	***Phone***
______________________________	____________	_____-_____-_____
Name (please print)	***Relationship***	***Phone***
______________________________	____________	_____-_____-_____
Name (please print)	***Relationship***	***Phone***

Please understand that we cannot share any information with your family and friends at any time unless they are listed above.

Patient Name:______________________________ **DOB:**_______________

Signature:______________________________**Date:**_______________

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