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:

_____ _____ Phone (___) _____-_____
Name (please print) Relationship

_____ _____ Phone (___) _____-_____
Name (please print) Relationship

_____ _____ Phone (___) _____-_____
Name (please print) Relationship

_____ _____ Phone (___) _____-_____
Name (please print) Relationship

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

_____
Patient Name

_____ _____
Signature Date