Patient Medical Authorization Form

PATIENT INFORMATION

Full Name

Date of Birth

Phone Number

Address

EMERGENCY CONTACT

Contact Name

Relationship

Phone Number

AUTHORIZATION

I hereby authorize the release of my medical information to the physicians, hospitals, or medical personnel involved in my care or payment of my care, as required. I authorize the listed emergency contact to make medical decisions on my behalf in the event that I am unable to do so.

Special Instructions (if any)

Patient Signature

Date

Parent/Guardian Signature (if minor)

Date