



Patient Name:

DOB:

Please list family members to whom your healthcare and/or billing information may be released.

- | | | | |
|----------|---------|---------|------|
| 1. _____ | medical | billing | both |
| 2. _____ | medical | billing | both |
| 3. _____ | medical | billing | both |
| 4. _____ | medical | billing | both |
| 5. _____ | medical | billing | both |

Signature

Date