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# MEDICAL INFORMATION RELEASE

I, _____, give permission for the following person(s) to obtain information from Dr. Evan Schiff and Dr. Helena Grabo's office regarding my personal medical records, care, and appointments.

Name:_____

Relationship:_____

Phone Number:_____

Is this person your emergency contact? [ ] Yes [ ] No

2nd Name If Necessary:_____

Relationship:_____

Phone Number:_____

Is this person your emergency contact? [ ] Yes [ ] No

**********

PATIENT SIGNATURE:_____

PATIENT DOB:_____

DATE:_____ Frontoffice/medinforelease 11/1/17