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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