Conroe Family Medicine
690 S Loop 336 W Ste 222
Conroe, TX 77304
936-756-6661

Authorization to release health care information

Patient's name: _____
Date of Birth: _____

It is ok to release any information about my medical records and health concerns to the following persons that I have listed (**EXAMPLE: spouse, parent, children, friends …**) This does not include other doctors offices.

Name _____ Relationship_____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Is it ok to leave a detailed message on your voicemail YES NO

I understand that my signed consent is required to release any and all healthcare information relating to testing, diagnosis, and/or treatment for sexually transmitted diseases, psychiatric disorders, or mental health disorders.

This authorization expires one year from date signed

_____ _____
Signature of Patient/Representative Date