Whole Life Health Care – Family Practice

Authorization to Speak with/or Release Information

I, ____, DOB: ________________,
(patient name)

give Whole Life Health Care Family Practice permission to speak with and/or release information about my medical care and treatment to:

____, _____________________
(name) *(DOB)*

who is my ____.
(relationship to patient)

This release of information will be valid unless Whole Life Health Care is notified in writing by patient.

* * * * * * *

____ _______________
Patient Signature Date:

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