RELEASE FORM FOR INDIVIDUALS INVOLVED IN CARE OF PATIENT

I,_____ give Dr. Jason Friesz's office permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans, and payment for health services I receive.

This consent is valid until such time as I provide a written revocation of it.

The office may speak with:

Name: _____ **Relationship**:_____
Phone #: _____
Information to be released:
Treatment_____ Diagnosis_____ Schedule_____ Payment_____

Name: _____ **Relationship**:_____
Phone #: _____
Information to be released:
Treatment_____ Diagnosis_____ Schedule_____ Payment_____

Name: _____ **Relationship**:_____
Phone #: _____
Information to be released:
Treatment_____ Diagnosis_____ Schedule_____ Payment_____

Name: _____ **Relationship**:_____
Phone #: _____
Information to be released:
Treatment_____ Diagnosis_____ Schedule_____ Payment_____

SIGNATURE: _____**DATE**:_____