Saginaw Valley Family Care

Release of Information Authorization

I hereby give permission for the following person or persons listed below (example: parents, spouse, children, relatives, significant other, etc.) to receive information regarding my medical care (example: appointment times, test results, medication, etc.) You may add or delete anyone at any time. This permission will be solely used by Saginaw Valley Family Care.

IF THE INDIVIDUAL IS NOT LISTED BELOW, WE CANNOT GIVE OUT ANY INFORMATION TO THEM.

_____ I WANT the following people to be able to discuss information regarding my medical care:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ I DO NOT WANT anyone, other than myself, to be able to discuss information regarding my medical care.

_____

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to Patient: _____

(If signed by Legal Guardian, or Representative)