Release of PHI to Emergency Contact

Authorization For Release

Patient Name:	**DOB:**
Address:	
City:	**State:**
Zip:	**I, (type name)**
Authorize the selected information may be discussed with the specified person below: ❑ Insurance ❑ Medical ❑ Scheduling Information	
Name:	**Relationship to Patient**
Address:	
City:	**State:**
Zip:	**Phone**
Signature of Patient	
Date:	
This authorization will remain in effect until revoked in writing upon request by patient	