CROWNVIEW MEDICAL GROUP, INCORPORATED

PERMISSION TO RELEASE INFORMATION BY TELEPHONE

Friends and family members may call the office and request information. It is against the law to inform anyone that you are a patient of this office or to give any information about your care and treatment unless you give written permission to do so. If you would like people designated by you to have information about your health, attendance in activities and that you are a patient in this office please complete the following information.

Any disclosure of information authorized by the patient is for the purpose of improving relationships with family and friends and to provide and maintain a family support system.

I hereby authorize CROWNVIEW MEDICAL GROUP, INC to release information limited to my general physical health and attendance in office appointments to.

Name	Relationship	Home/Work Phone
Name	Relationship	Home/Work Phone
Name	Relationship	Home/Work Phone
Name	Relationship	Home/Work Phone

Patient/Guardian Signature _____ Date _____

NON-DISCLOSURE OF INFORMATION

I do not wish knowledge of my condition to be released to anyone.

Patient/Guardian Signature _____ Date _____