Release of Medical Information
(Please print clearly and fill out entirely)

Patient Name (please print) ............................................................................................................. Date of Birth

By completing this section, you are authorizing Sparrow Medical Group to release information (verbally or over the phone) to people you have designated. If there are no names written in the section below we WILL NOT be able to release any information to anyone other than YOU.

Name  _____________________________________ Relationship________________________
Name  _____________________________________ Relationship________________________
Name  _____________________________________ Relationship________________________

By completing this section, you are authorizing Sparrow Medical Group to leave a detailed message on an answering machine or voicemail (For example: Non-urgent lab or x-ray results, information on a referral to see a specialist, appointments, etc.). If the phone number is for a parent or guardian, please also provide his/her name.

Phone Number  ____________________  Name_______________________________________
Phone Number  ____________________  Name_______________________________________
Phone Number  ____________________  Name_______________________________________

* * * * * * *

NOTE: A SIGNATURE IS REQUIRED BELOW EVEN IF NO ONE IS LISTED ABOVE
By signing this form, I understand that this release will stay in effect until written consent is given updating this information.

Patient’s Signature .......................................................................................................................... Date

Parent/Guardian Name (please print) ............................................................................................................. Parent/Guardian Signature