

Patient's Release of Information to Individuals

I, _____, give the staff of Stonebridge Internal Medicine, permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from Stonebridge Internal Medicine.

This consent is valid until such time as I provide Stonebridge Internal Medicine written revocation of it.

The staff of Stonebridge Internal Medicine may speak with:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Signature of Patient: _____

Date: _____