



RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: ____/____/____

I give North Oaks Clinic permission to verbally share my treatment (for example, test results, medications, treatment alternatives) or any other personal health care information and information regarding payment for services to the following:

DATE	NAME	RELATIONSHIP

Patient's Signature

____/____/____
Date

I understand that I must submit a written request to rescind any or all of the above-listed individuals.