Patient #_____

Consent to Release Information

I,_____, give the physicians and office staff of mountain Region Family Medicine permission to discuss my medical condition with:

With:_____
Who is: _____Phone: _____
(Relationship)

With:_____
Who is: _____Phone: _____
(Relationship)

With:_____
Who is: _____Phone: _____
(Relationship)

With:_____
Who is: _____Phone: _____
(Relationship)

May we confirm appointments by answering machine?_____

May we leave test results on you answering machine?_____

May we contact you at work? _____

_____ _____
Patient Signature & Date of Birth Date

This is an indefinite consent form unless otherwise specified.