Patient Name: ______________________________ Date of Birth: _____________

Patient Address: ____

Patient Phone Number: ____

I consent to the release of my medical record to:

☐ Myself at the following address:

____

____

____

____

☐ Another medical provider at the following address:

____

____

____

____

By signing this consent form, I authorize Family Health Enterprises to disclose my health information. I further understand that I am under no obligation to sign this form and have signed this form to voluntarily document my wishes regarding the disclosure of my medical record as described above.

____ ________________

Patient Signature Date

____ ________________

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