MEDICAL INFORMATION AUTHORIZATION

Patient Name: _____ Date of Birth: ____/_____/_____

I authorize the personnel of Alonso Medical and Wellness Center to release all medical information to my family/friends listed below:

I may revoke this authorization by phone or in writing at any time.

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

Permission to leave a message on an answering machine or voicemail please sign below

Patient Signature: _____ _____ Date: ___/___/____