**RELEASE FORM FOR INDIVIDUALS INVOLVED IN CARE OF PATIENT**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give Dr. Jason Friesz’s office permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans, and payment for health services I receive.

This consent is valid until such time as I provide a written revocation of it.

The office may speak with:

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
*Information to be released:*   
Treatment\_\_\_\_\_\_\_ Diagnosis\_\_\_\_\_\_\_ Schedule\_\_\_\_\_\_\_ Payment\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
*Information to be released:*   
Treatment\_\_\_\_\_\_\_ Diagnosis\_\_\_\_\_\_\_ Schedule\_\_\_\_\_\_\_ Payment\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
*Information to be released:*   
Treatment\_\_\_\_\_\_\_ Diagnosis\_\_\_\_\_\_\_ Schedule\_\_\_\_\_\_\_ Payment\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
*Information to be released:*   
Treatment\_\_\_\_\_\_\_ Diagnosis\_\_\_\_\_\_\_ Schedule\_\_\_\_\_\_\_ Payment\_\_\_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_