John Petty, M.D., John C. Jump, M.D., Daniel E. Braunlin,M .D., Richard T. Beers, M.D.

Diplomates, American Academy of Physical Medicine & Rehabilitation / Diplomates, American Board of Electrodiagnostic Medicine

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RELEASE OF MEDICAL RECORD INFORMATION

PATIENT NAME _____

PATIENT DOB: _____

☐ I do **not** give permission for information pertaining to my medical history released to another family member.

☐ I **do** give permission for my medical information to be released to the following:

NAME	RELATION TO ME

Do you want us to leave information regarding your medical history on your answering machine?

Yes_____ No_____ What number do you want us to call?_____

Patient Signature_____

Date _____