TULIP TREE
FAMILY HEALTH CARE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY/FRIENDS

Patient Name:_____ DOB:_____ SSN:_____

Address:_____ City_____ ST_____ ZIP_____

Phone No._____

NOTE: Behavioral Health Records Will NOT Be Released
Without Completing A Specific Behavioral Health Release Form

Please List ALL the Names and Relation To Patient Below That you Authorize Tulip Tree Staff to Release Your Medical Information To:

Name	Relationship	Phone #

Information You Authorize to be RELEASED:

Please check all that apply:

____ALL Medical Information (including appointments, medications, results, referrals, etc)

____ONLY Appointment Information

____ONLY Lab Test & Diagnostic Results

____Other (Please Specify)_____

_____
Signature of Patient Date

_____
Signature of Witness Date

_____
Signature of Authorized Person/Relationship Date