

# MEDICAL RELEASE FORM

I \_\_\_\_\_, GIVE PERMISSION TO THE FOLLOWING PEOPLE LISTED BELOW FOR ANY MEDICAL RELEASE OF INFORMATION PERTAINING TO MYSELF. I UNDERSTAND THAT I CANNOT HOLD PENINSULA NEUROLOGY RESPONSIBLE FOR ANY INFORMATION THAT WAS GIVEN TO THE PEOPLE BELOW I HAVE LISTED.

	<u>NAME</u>	<u>RELATIONSHIP</u>	<u>CONTACT#</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_