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Wright & Associates Family Healthcare

Amherst

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PERSONAL/PRIVATE HEALTH INFORMATION RELEASE REQUEST

Patient Name: ______________________ D.O.B.: __________________

I, ____________________, authorize Wright & Associates Family Healthcare and/or his agent(s) to release any and all of my personal/private health information to:

____________________________________	____________________________________
Legal Name	Relationship
____________________________________	____________________________________
Legal Name	Relationship
____________________________________	____________________________________
Legal Name	Relationship
____________________________________	____________________________________
Legal Name	Relationship

I understand that some information contained in my record may be sensitive in nature. I also understand that any change in this release/request must be made in writing.

Date: _____________ Signature: _____________________________