Osteopathic
Wellness Medicine
of Western New York

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize this facility to speak to the following family members or my personal representative regarding:

□ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, doctor's notes and any other non-medical information in my file.
□ Only the following information:
_____
_____
_____

The above medical information shall only be released or discussed with the following persons:

Name of Personal Representative	Relationship	DOB	Phone#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one)
□ Until revoked in writing.
□ Until _____, 20____

Name: _____ _____
Patient Name Witness

_____ _____
Signature Witness Signature

Date: _____