



Patient Name: _____

Patient DOB: _____

I, _____ give _____
(Patient name) (Person who may receive information)

permission to inquire and receive information contained in my medical record at Partners in Internal Medicine. In addition, the above named person may inquire and receive information from the staff at Partners in Internal Medicine in regards to my presence in the office, any test results, any testing or physician visits ordered by my primary care physician, and/or dates of treatment.

Partners in Internal Medicine will give the information only to the person named above (with the exception of medical use by physician and clinical staff) and will not be held liable for doing so.

This authorization remains valid unless revoked by me in writing.

Patient Signature: _____

Witness: _____

Date: _____