EDWARD C. MURPHY, M.D., PA

CONSENT TO RELEASE MEDICAL INFORMATION TO FAMILY / FRIEND(S)

PATIENT NAME: ______________________________

D.O.B. _________________

I, _____________________ Authorize the office of Dr. Edward C. Murphy to release my medical information to the following individual (s):

Name: _________________________

Phone: _________________________

Relation: ________________________

Name: _________________________

Phone: _________________________

Relation: ________________________

☐ **CHECK HERE IF YOU DO NOT WISH TO AUTHORIZE THE RELEASE OF YOUR MEDICAL RECORDS TO ANYONE.**

PATIENT SIGNATURE: _______________________________

DATE: ___________________