

Sakura Women's Health
611 S Chestnut, Ste D
Ellensburg, WA 98926
(509) 933-8700

Release of Medical Information to Family or Others

Patients Name _____ DOB _____

Patients Signature _____ Date _____

I the above stated patient authorize the following listed person/persons to be involved in my medical care indefinitely. I authorize the above physician's office to release:

FINANCIAL

Verbal

Written

MEDICAL INFORMATION

Verbal

Written

All of the above

If I would like to revoke this request I must submit the request in writing.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____