Agave Family
Physicians, PLLC

Consent To Release Information

PATIENT IDENTIFICATION:

Patient Name: _____ **Date Of Birth:** _____

CONSENT:

I, _____, grant the following individuals permission to access my patient information from Agave Family Physicians PLLC including examination, treatment, or surgical procedures. I furthermore grant these individuals permission to pick up any documents, obtain appointment information, or to be informed of treatments and diagnosis.

Please list name, date of birth, and relationship to patient

_____

_____

_____

MESSAGES:

I, _____, grant Agave Family Physicians permission to leave telephone messages with confidential patient information such as lab results, medication information, etc. at the following telephone number. In the event that this number might change, I understand that I will be responsible for informing the office of this updated information.

Telephone Number: _____

EMERGENCY CONTACT:

Name: _____ **Telephone Number:** _____

Relation To Patient: _____

REVOCATION:

This authorization may be revoked, in writing, at any time.

Signature: _____ **Date:** _____