Dublin Family Care, Inc.
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CONSENT TO RELEASE MEDICAL INFORMATION

I_____ Date of Birth_____

(Please Print Name)

Give Dublin Family Care permission to release my medical information to the following individuals.

Name:_____ Date of Birth:_____

Relationship:_____ Phone #:_____

Name:_____ Date of Birth:_____

Relationship:_____ Phone #:_____

☐ I refuse to have my medical information released to any individual.

I give Dublin Family Care permission to leave detailed medical information on my voice mail at the following phone number:_____

Signed:_____ Date:_____

Witness:_____ Date:_____