



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION  
TO TWO FAMILY MEMBER**

I hereby consent to the release of my TREATMENT PLAN, TEST RESULTS AND ANY MEDICAL INFORMATION TO:

Contact #1 \_\_\_\_\_  
Name Relationship Phone Number

Contact #2 \_\_\_\_\_  
Name Relationship Phone Number

\_\_\_\_\_  
Signature of responsible party Date Relationship to Patient