HAROLD F. ROTH, D.O.
GENERAL PRACTICE

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MEDICAL RELEASE

I give Harold F. Roth, D.O. permission to discuss my care with the following person(s).
(This includes billing and appointment information)

_____ _____
Print Name **Relationship**

_____ _____
Print Name **Relationship**

_____ _____
Print Name **Relationship**

_____ I give permission to physician and/or staff to release my lab, x-ray results or <u>any</u>
Initials information to the persons(s) listed above over the phone.

_____ I give permission to physician and/or staff to release my lab, x-ray results or <u>any</u>
Initials information by leaving a message on my answering machine/voicemail.

I understand that this release will stay in effect until written consent is received altering its contents. It is my responsibility to notify Harold F. Roth, D.O. of any changes.

_____ _____
Print Patient Name **Date**

_____ _____-_____-_____
Patient Signature **Patient Social Security Number**

_____
Signature of Guarantor/Legal Guardian

Revised 10/15/14.cmf