Preferred Family Clinic
1355 N. University Ave. Ste 200
Provo, UT 84604
(801) 221-0223

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Account Number: _____

I understand in order to gain the most benefit from a treatment process, it is essential information be exchanged between Preferred Family Clinic and the person(s) or organization identified below.

_____
Primary Physician's Name

_____
Physician's Group/Business Name

_____
Physician's Address, City, Zip Code

__(___)_____
Telephone Number

I also authorize Preferred Family Clinic to correspond with the person(s) or organization named above and to keep him/her informed of the patient's treatment plan and progress.

A copy of this consent shall be as valid as the original. This consent is subject to written revocation except to the extent that action has already been taken on it.

**This authorization for release of information will expire on _____
Future Date

_____ **I decline to give authorization for any release of information.**

_____ _____
Signature of Patient or Guardian **Date**

_____ _____
Signature of Witness **Date**