# Patient Emergency Contact and Release Authorization Form

Please complete this form to designate your emergency contacts and authorize the release of your medical information. This form is for printing and manual completion or record-keeping.

## 1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

## 2. Primary Emergency Contact

Contact Full Name:

Relationship to Patient:

Primary Phone Number:

Alternate Phone Number:

## 3. Secondary Emergency Contact

Contact Full Name:

Relationship to Patient:

Primary Phone Number:

## 4. Medical Information Release Authorization

I authorize the medical facility and its staff to share, discuss, and release my medical records, diagnosis, and treatment plans to the following designated individuals:

### Authorized Person 1

Full Name:

Relationship to Patient:

Phone Number:

### Authorized Person 2

Full Name:

Relationship to Patient:

Phone Number:

## 5. Authorization Signature

By signing below, I acknowledge that this authorization remains in effect until I submit a written revocation to the medical facility.

Patient/Guardian Signature (Physical signature required upon printing):

X_____

Date Signed (MM/DD/YYYY):

Witness Full Name:

Witness Signature (Physical signature required upon printing):

X_____