Consent to Release Medical Information

Grove City Family Health

6024 Hoover Road, Suite A, Grove City ,OH 43123 614-875-8949

I ____ Date of Birth: ________________

(PLEASE PRINT NAME)

Give Grove City Family Health permission to release my medical information to the following individuals.

Name: ____ Date of Birth: ________________

Relationship: _____________________________________ Phone #: ____________________

Name: ____ Date of Birth: ________________

Relationship: _____________________________________ Phone #: ____________________

Name: ____ Date of Birth: ________________

Relationship: _____________________________________ Phone #: ____________________

I Give Grove City Family Health permission to leave detailed medical information on my voice mail at the

following phone number: ____

Signed: ____ Date: ________________________

Witness: ____ Date: ________________________