# Release of Confidential Information

I, _____, give my consent to Dr. Michelle Bretzius and 302 Family Medicine to release my confidential information, including but not limited to Protected Health Information, Appointments, and Billing/Payment Information, as noted below. I hereby release Dr. Michelle Bretzius and 302 Family Medicine of any liability in the event I suffer any consequences regarding the release of this information to the named individual(s).

☐ I **DO NOT** authorize anyone to receive my confidential information.

☐ I hereby authorize release of my confidential information to the individual(s) listed below.

1) Name: _____ Relationship: _____

Phone: _____

2) Name: _____ Relationship: _____

Phone: _____

_____ _____

**Patient or Parent/Guardian Signature** **Date**