

GENERAL AUTHORIZATION*

Patient/Parent/Legal Guardian Signature

Date

Name (please print or type):

If the above name is not the patient, please state your relationship to the patient (i.e. parent, legal guardian):

ORAL AUTHORIZATION - NOT APPLICABLE TO HIV RELATED INFORMATION

I witness that the person understood the nature of this release and freely gave his/her oral authorization.
(Two witnesses are required)

Witness #1

Date

Witness #2

Date

Office Use Only ***Copy provided to patient** **Signature:** _____

***Copy must be provided if request for authorization is from individual/entity other than the patient or patient representative.**