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REQUEST / AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's name _____

DOB _____

I hereby authorize and give my full consent that Dimitry Francois MD PLLC contact, and obtain and/or provide, my medical history and other related information from/to the following people or organizations:

Name / Facility	Telephone / Fax
_____	_____
_____	_____
_____	_____
_____	_____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that this correspondence may involve a conversation or a transfer of written material. I understand that I may revoke this consent at any time, except to the extent that action based on this consent has already been taken. This consent will be considered valid for the duration of your treatment, until revoked in writing.

Signature _____

Printed name _____

Date _____