King Family Medicine
We take the time to care.

I, _____, give my permission for my reports and/or appointments to be released to the following individual(s):

NAME	**RELATIONSHIP**	**PHONE NUMBER(S)**	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ANSWERING MACHINE: **YES** **NO**

_____

Patient's Signature