

Information Release Form

Patient Name: _____

___ Yes ___ No

I authorize IKP Family Medicine to
Mail lab results to me.

___ Yes ___ No

I authorize IKP Family Medicine to release
Medical records to other requesting Physicians.

___ Yes ___ No

I authorize IKP Family Medicine to
Discuss medical issues, records, lab results and
Diagnostic test to the name(s) listed below.

Please list the full name(s) and relationship to patient:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Signature: _____ Date: _____