Family Release

I, ______________________________, give my consent for the office of Dr. Jeffrey Potts, M.D. to release information concerning my medical condition, treatment, and results of any test by my physician to my family members listed below.

Name	Relationship	Phone
______________	______________	______________
Name	Relationship	Phone
______________	______________	______________

______________________________   ______________

Patient's Signature   Date

All Patients:

We are required to inform you of our company policy on Privacy Practices. The attached sheet is for you to keep and read. You must sign below as verification for our records that you have received this information from our company.

The undersigned patient or legally authorized representative acknowledge that he or she personally received a copy of the Notice of Privacy Policies on the date indicated below.

______________________________   ______________

Patient Signature   Date