



RELEASE OF CONFIDENTIAL INFORMATION

_____, 20____

This Release of Confidential Information allows my person of choice stated below to act on my behalf for the purpose of inquiring and/or obtaining my confidential health information.

I, _____ of

(Address) (City, State, Zip) (Phone)

have allowed _____ of
(Name)

(Address) (City, State, Zip) (Phone)

to act on my behalf for the purpose stated above.

I authorize MCEBP to release any or all information relating to my health information to the named person.

Signature _____