Chart #_____

Patient: _____

Date of Birth: _____

By signing this form, I authorize medical test results to be given to the parties indicated below. I understand that I may revoke this at any time by a written statement.

List person(s) to give test results to: _____ *(name/relationship)*
_____ *(name/relationship)*

_____Do not give medical test results to anyone except me.

Primary phone number for test results: _____

Patient or Parent if minor: _____Date:_____
(signature)