

RELEASE OF TEST INFORMATION

Patient Name: _____

Date of Birth: _____

I _____, give my consent to the staff of Sage Health Family Medicine to
patient name
relay any lab results, x-ray and other radiology testing, referral information or any other important
medical information to:

Please check the following:

YES **NO**

 _____(name) _____ (relationship)

 _____(name) _____ (relationship)

 answering machine at home

 myself, at place of employment

TEL (____) _____ - _____

Date _____ Signature _____