WILLLIAM A. HAMILTON, M.D., F.A.C.O.G.
619 Jefferson Davis Highway, Suite 101
Fredericksburg, VA 22401
Phone-540-373-4700 Fax-540-373-5635

REQUEST TO RELEASE MEDICAL INFORMATION TO CAREGIVER OR FAMILY MEMBER

Today's Date: ____

Patient's Name: ______________________________ Birth Date: ___________

Address: ____

____

Phone Number: (____) ____________________ Account Number: ___________

I give my permission to Dr. Hamilton and staff to release my medical information to:

Name: ________________________________ Relationship: ________________

Address: ____

____

Phone Number :(_____) ________________

____

Signature of patient or legal representative