Lanier Family Healthcare, LLC

Gary S. Orris, MD

Authorization to release information to Family Member or Friend

I, _____, am authorizing Lanier Family Healthcare, LLC.
(Patient's Name)

to release any of my medical information to _____, if they
(Family Member or Friend)

should call or write on my behalf. This authorization is effective _____ and will
(start date)

not expire until further notice in writing.

Signature _____
(Patient's Signature)

Date _____
(Today's Date)

OPT to Decline _____
(Patient's Signature)

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