

PATIENT CONSENT FOR RELEASE OF PERSONAL HEALTH INFORMATION

I, _____ have read the privacy of Lillian Medical Clinic, and I understand that Lillian Medical Clinic strives to protect my privacy as related to any and all individually identifiable health information concerning me. I hereby give my permission for Doctor Coyle and employees of Lillian Medical Clinic to release or discuss my personal health information to:

- 1. _____ Relationship to Patient _____
- 2. _____ Relationship to Patient _____
- 3. _____ Relationship to Patient _____
- 4. _____ Relationship to Patient _____