



Main Street Family Practice, P.C.

Dario L. Lizarraga, M.D. Marcee Wharton, P.A.-C

My signature below authorizes Main Street Family Practice to release medical information and or test results regarding my treatment with the following people:

_____ Birthdate: _____ Phone# _____

_____ Birthdate: _____ Phone# _____

The following information will be discussed by phone or in person only. This does not authorize the release of written medical records.

Patient's Printed Name

_____ Date: _____
Patient/Guardian Signature