Main Street Family Practice, P.C.

Dario L. Lizarraga, M.D. Theresa Koppal, P.A.-C Catherine O'Neill, F.N.P.-C

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

_____ **Relationship:** _____ **Phone#**_____

_____ **Relationship:** _____ **Phone#**_____

_____ **Relationship:** _____ **Phone#**_____

_____ **Relationship:** _____ **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