



EAGLE'S LANDING FAMILY PRACTICE, INC.

Date: _____/_____/_____

I, _____, hereby give permission to Eagle's Landing Family Practice, Inc., to release any and all results to the person or persons listed below:

Name: _____ Social Security #: _____-_____-_____

Relationship: _____

Name: _____ Social Security #: _____-_____-_____

Relationship: _____

This authorization shall be in effect until such time as I request, in writing, that it be changed.

Patient Signature

Witness