

First Choice Medical  
203 Union Avenue  
Holbrook, NY 11741



(631) 585-5858  
FAX (631) 585-6362

**Authorization to Release Health Care Information to Your Family and Friends:**

I authorize you to use, release or disclose my healthcare information for treatment, payment or for healthcare operations to the following family members and friends. This authorization will remain in affect unless revoked by me in writing.

<b>Name</b>	<b>Relationship to Patient</b>
_____	_____
_____	_____
_____	_____
_____	_____

**Signature of Patient, Parent or Guardian:**

\_\_\_\_\_

**Date:** \_\_\_\_\_