

Swetang Patel, M.D., P.A.
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**PATIENT CONSENT FOR RELEASE OF
MEDICATION(S) AND/ OR MEDICAL INFORMATION**

**BY SIGNING THIS CONSENT FORM I AM ALLOWING
SWETANG PATEL, M.D., P.A.**

**TO RELEASE MY MEDICATION(S) AND/ OR MEDICAL INFORMATION
TO:**

**NAME OF PERSON RECEIVING INFORMATION
(example: Husband, Wife, Sister, Brother, etc.)**

CONSENT VALID UNTIL REVOKED BY PATIENT OR LEGAL GUARDIAN

**I DO NOT WISH TO HAVE MY MEDICATIONS(S) OR ANY MEDICAL
INFORMATION RELEASED TO ANYONE**

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

TODAY'S DATE

HOME OR CELL NUMBER

SIGNATURE OF WITNESS

TODAY'S DATE