Fairfield INTERNAL Medicine, Inc.

PATIENT CONSENT TO RELEASE INFORMATION

I do hereby authorize the physicians at Fairfield Internal Medicine, Inc., Dr. John Abidin, Dr. Michael Murray and Dr. Christopher Nickison to release medical information and/or to discuss my own personal health records and/or my current condition to members of my family and/or friends as listed below.

I authorize the family/friends listed below to pick up on my behalf prescriptions, lab/test orders, or other medical papers from the office of Fairfield Internal Medicine, Inc. if I instruct them to do so.

I may cancel, change or withdraw this consent at any time by notifying Fairfield Internal Medicine, Inc. or one of its physicians in writing.

_____ _____

Patient's Signature Date

_____ _____

Witness Date

Authorized Family/Friends:

_____ _____

Name/Relationship Phone Number

_____ _____

Name/Relationship Phone Number

_____ _____

Name/Relationship Phone Number

Emergency Contact (relative and/or friend not living with you):

_____ _____

Name/Relationship Phone Number