

**CATHY T. LARRIMORE, MD AND ASSOCIATES**

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**CONSENT TO RELEASE INFORMATION**

The HIPAA Privacy Act prevents us from disclosing information about you to others. Therefore, if you would like us to share any information with others (including family members) regarding your information please enter the required information and sign the Form below. Unless this is signed, we cannot give information to anyone, including acknowledging that you are our patient.

I \_\_\_\_\_ give permission to CATHY T. LARRIMORE, MD & ASSOCIATES to release and share information regarding my health status to the following person/people:

(1) \_\_\_\_\_ relationship \_\_\_\_\_

(2) \_\_\_\_\_ relationship \_\_\_\_\_

(3) \_\_\_\_\_ relationship \_\_\_\_\_

(4) \_\_\_\_\_ relationship \_\_\_\_\_

(5) \_\_\_\_\_ relationship \_\_\_\_\_

This consent covers all aspects of medical care.

Agreed to this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Witness