The Senator William and Ellen Proxmire Memory Clinic
At Copper Ridge

Release of Medical Information

I _____ do authorize
Name Of Patient Or Healthcare Power Of Attorney On Patient's Behalf

The Senator William and Ellen Proxmire Memory Clinic at Copper Ridge to release any and all findings and information to:

Name: _____
Address: _____
_____
Phone Number: (____)_____ - _____
Fax Number: (____)_____ - _____

in connection with my examinations, care, and treatment to include any additional testing during the period _____end.

From

I understand that I may revoke this consent to release information from my records, but not retroactive to release of information already made in good faith.

_____ Date: ___/___/_____
Patient Signature

_____ Date: ___/___/_____
Signature of power of attorney, parent, relative, or legal guardian, where applicable.

_____
Address of signee if not patient

_____
Relationship to patient

_____ Date: ___/___/_____
Witness