J.Schwartz, M.D., PLLC

137 Hoosick Street

Troy, NY 12180

(518)274-4305

I ___________________________________ DOB ______________

Give permission to Dr. Schwartz and his staff to discuss my medical history, including appointments, medications, treatment, and prognosis, as well as billing information to the following individuals:

____ Relationship _____________

____ Relationship _____________

____ Relationship _____________

Any restriction to the release of information, please list below

____

____

Signature of patient or legal guardian ____________________________________

Date _________ Witness ____