RELEASE FORM

Raynon A. Andrews, M.D., P.C.

I, _____ give Raynon A. Andrews, M.D., P.C., permission to speak to the following individuals regarding my health status, diagnosis, treatment options/plans and payment for health services while I am under the care of Raynon A. Andrews, M.D., P.C..

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

This release form is valid until I notify Raynon A. Andrews, M.D., P.C. in writing any changes that are to take place to this release form.

Name:_____ Date:_____