



# Lanier Family Healthcare, LLC

Gary S. Orris, MD

## Authorization to release information to Family Member or Friend

I, \_\_\_\_\_, am authorizing Lanier Family Healthcare, LLC.  
(Patient's Name)

to release any of my medical information to \_\_\_\_\_, if they  
(Family Member or Friend)

should call or write on my behalf. This authorization is effective \_\_\_\_\_ and will  
(start date)

not expire until further notice in writing.

Signature \_\_\_\_\_  
(Patient's Signature)

Date \_\_\_\_\_  
(Today's Date)

OPT to Decline \_\_\_\_\_  
(Patient's Signature)