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Authorization to Release (**ATR**) Information / In Case of Emergency (**ICE**) Contacts

Patient Name________________________________ Date of Birth________________________________

I authorize the release of healthcare information to the following individuals for assisting in my care-taking and/or in case of emergency.

Name | Phone Number | ATR | ICE

1) ______________________________ ___________________________ ☐ Yes ☐ No ☐ Yes ☐ No

Relationship to Patient: ___________________________

☐ Address is same as patient's.

Address:____

2) ______________________________ ___________________________ ☐ Yes ☐ No ☐ Yes ☐ No

Relationship to Patient: ___________________________

☐ Address is same as patient's.

Address:____

3) ______________________________ ___________________________ ☐ Yes ☐No ☐ Yes ☐ No

Relationship to Patient: ___________________________

☐ Address is same as patient's.

Address:____

This request applies to:

☐ All/or healthcare information in respects to the following limiting factors:

____

Patient Signature: __________________________ Date Signed: _____________________________

Parent/Guardian Printed: __________________________ Relationship to Patient: _____________________________

Parent/Guardian Signature: __________________________ Date Signed: _____________________________