EDWARD NEGOVETICH, MD

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MEDICAL IMFORMATION RELEASE

I, ______________________________ D.O.B. ____________________
(patient name)
grant permission for ____
(name of doctor or facility)
To disclose/release to ***Dr. Edward Negovetich*** the ☐ entire file or ☐ medical notation & findings for the treatment of

____

____.

I release ______________ABOVE MENTIONED FACILITY OR PHYSICIAN______
(name of doctor or facility)
From any laws related to disclosure/release of confidential and privileged information.

Signature __________________________ Date ______________________

Witness ___________________________ Date ______________________