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**DISCLOSURE RELEASE**

**This form authorizes Dr. Allen/Dr. Cowart/Dr. Cost/Dr. Garrard or their staff to discuss my medical conditions and test result with the person(s) stated below--including the authorization to pick up prescriptions and/or letters on my behalf.**

Name of Person(s):

Relationship to Patient:

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**OR**

**No one. I understand by electing to list no one on my disclosure, that I will be the only person who may obtain information or pick up prescriptions and/or letters from this office.**

**I understand this form is valid until I complete a new form; I may cancel this authorization by sending a letter to the office or completing a new form.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (please print)