Ridge Family Practice, P.C.

• Clarine I. Coker, M.D.
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Information Access

Patient Name: ______________________________ Date of Birth: ____________________

I ______________________________________, hereby authorize the following person/people to have access to my medical information for the period defined:
__/__/__ - __/__/__ or indefinitely

(circle all that apply) Medical / Billing / Both

Name: ____
Phone: ____
Relationship to patient: _________________________

Name: ____
Phone: ____
Relationship to patient: _________________________

Name: ____
Phone: ____
Relationship to patient: _________________________

Patient Signature	Date	Witness Signature

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