# GRAND FORKS COUNTY MEDICAL DATA RELEASE / WAIVER

I, _____, the undersigned hereby authorize: (the following person(s), agencies, medical/mental health clinics, hospitals)

_____

_____

_____

_____

to release and/or exchange information on file regarding my medical shot records.

This aforementioned information can either be oral or written and is not limited to any specific time period, incident or circumstance, but may be in reference to any or all available information.

I hereby release you and the medical facility providing data requested in connection with this instrument from any and all liability. I further waive any rights I may have under any State or Federal law that protect the requested data from disclosure.

A photocopy of this Release/Waiver is as effective and binding as the original and is valid for a period of six (6) months subsequent to the date designated under my signature.

(Date of Medical Attention) _____

(Signature) _____ (Date) _____

(Print name) _____ (Dob) _____

(Witness) _____ (Date) _____