Clarine I. Coker, M.D.

Jennifer S. Kay, M.D.

Alan Pokorski, P.A.

Jill R. Sobczyk, P.A.-C

Christy M Quillen, A.R.N.P

Patient Name: ____

Address: ____

Phone: (___) - _______________ Date of Birth: ___ /___ /___

I ____, hereby authorize the following people/person to have access to my medical records.

Name: ____

Address: ____

Phone: ____

Relationship to patient: ______________________________________

Name: ____

Address: ____

Phone: ____

Relationship to patient: ______________________________________

Patient Signature: ________________________________ Date: ______________

Witness Signature: ________________________________ Date: ______________