AUTHORIZATION TO RELEASE INFORMATION

I,_____, hereby authorize **Rockwall County Indigent Health Care** to speak with family members/friends, listed below, regarding issues or questions pertaining to my client status with the program.

Name:_____ Phone:_____

Relationship:_____

Name:_____ Phone:_____

Relationship:_____

Name:_____ Phone:_____

Relationship:_____

Signature_____ Date:_____