TRAIL RELEASE OF MEDICAL INFORMATION FORM

TRAIL Member Name: _____

TRAIL Medical Advocate Volunteer Name: _____

As a member of TRAIL and their medical advocacy program, I authorize the release of my medical information (including diagnosis, treatments and examinations) by the TRAIL Medical Advocate Volunteer named above to:

Relationship to TRAIL Member: _____

Name: _____

Address: _____

Phone(s): _____

_____ Date: _____
Signature of Trail Member (This authorization will not expire)

_____ Date: _____
Signature of Trail Medical Advocate (This authorization will not expire)

***A copy of this release will be maintained by both the TRAIL member and the TRAIL medical advocate volunteer.**