

**BANDER FAMILY MEDICAL
RELEASE OF MEDICATION HISTORY**

Bander Family Medical has my permission to retrieve my medication history information by any means available to the office. I understand that this is a one time only permission agreement. I understand that this agreement is to allow Bander Family Medical to treat and meet my medical needs.

Patient Print Name

Patient Signature
(if under 18 years of age, Guardian Signature)

Date

Employee Witness

Patient Chart #/DOB
(Employee Use Only)