

Pedro E. Estorque Jr., M.D., P.A.  
2625 Scripture Street, Suite 103, Denton, Tx. 76201

## Patient Consent To Release Protected Health Information

**\*\* Please Complete, Sign and Date**

The following name(s) are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Pedro E. Estorque Jr., M.D., P.A. to share my protected health information with:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

**I DO NOT WANT MY PROTECTED HEALTH INFORMATION RELEASED TO ANYONE OTHER THAN MYSELF.**

\_\_\_\_\_  
Patient's (or Legal Guardian) Signature

\_\_\_\_\_  
Date