AUTHORIZATION TO RELEASE
PERSONAL HEALTH INFORMATION

Name of Patient: ____

Previous Patient Name(s): ____

Date of Birth: ____

North American Malignant Hyperthermia Registry Number(s): __________

____

I authorize the North American Malignant Hyperthermia Registry to release any records pertaining to my case to the person(s) listed below.

____

Signature of Patient or representative   Date

Name: ____

Relationship to Patient: ____

Institution (if applicable): ______________________________________

Mailing Address: ____

____

Phone Number: ____

Fax Number: ____