Jason E. Mastor, MD

Kristin C. Brown, PA-C

LIFETIME SIGNATURE AUTHORIZATION

I authorize the release of medical information to the below named family member, Acting Power of Attorney or Health Care Surrogate. I will notify this office in writing if this information should change.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Patient Signature	Date
_____	_____
Physician/Supplier	Date

*** A photocopy of this form will be as valid as the original form.***