Jason E. Mastor, MD

Kristin C. Brown, PA-C, MMS **DIANA REMENAR, PA-C**

Megan Flott, 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	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____

_____ _____

Patient Signature Date

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