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Authorization to Release Medical Information

Patient Name _____

In the event that you must be contacted for matters relating to test results, referrals, or other medical information, please let us know how you prefer this to be carried out. Please mark one or all of the following that apply:

_____Leave message at home

_____Contact me by secure email _____

_____Leave message with (name) _____ at (number)

_____

_____Leave message at my place of employment at (number) _____

_____Leave message on cell phone voice mail _____

_____You may discuss my information with the following emergency contacts:

_____ (number) _____

Or with _____ (number) _____

Patient Signature _____ Date of birth _____