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Good Medicine Takes Time

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name _____ Date of Birth _____/_____/_____

Release of information

[ ] I authorize the release of verbal information, including the diagnosis, records, diagnostic studies, examination rendered to me, and claim information. This information may be released to:

[ ] Spouse

[ ] Child(ren) Name: _____

[ ] Other_____

[ ] My information is not to be released to anyone

Leaving Messages

Please call [ ] my home [ ] my work [ ] my cell phone

If you're unable to reach me:

[ ] you may leave a detailed message

[ ] please only leave a message asking me to return your call

The best day to reach me in (day)_____ between (time)_____

This release of information will remain in effect until terminated in writing by patient

Signed: _____ Date: _____

Witness: _____ Date: _____