

Any information related to my medical care is considered confidential and will not be released to anyone without my permission. I hereby give permission for any medical information related to my treatment to be given to:

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

THIS OFFICE MAY: (CHECK ALL THAT APPLY)

_____ Leave test results on your cellphone (number) _____

_____ Leave a message at work to call the office (work number) _____

_____ Leave a message on my home answering machine to call the office _____

_____ Leave test results on answering machine

_____ Send medical information to any healthcare provider that I am referred to (lab, physicians, etc.)

_____ NONE OF THE ABOVE

PRINT PATIENT NAME _____

PATIENT OR LEGAL
GUARDIAN SIGNATURE _____ DATE _____