AUTHORIZATION FOR RELEASE OF INFORMATION

____ **I DO** WISH (WHEN APPLICABLE) TO ALLOW PERSON(S) LISTED BELOW TO CALL/RECEIVE PHONE CALLS, HAVE TEST RESULTS OR OTHER INFORMATION DISCUSSED ON MY BEHALF.

____ **I DO NOT** WISH TO ALLOW ANYONE BUT MYSELF TO CALL/RECEIVE PHONE CALLS, HAVE TEST RESULTS OR OTHER INFORMATION RELEASED REGARDING MY CARE.

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must fill out another Authorization of Release of Information.

Patient signature:_____

Date: _____

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