Stafford Medical, P.A.

Health Information Release

This is to certify that I _____

request that my medical information only be released to:

Names:

- ○ Family_____
- ○ Medical _____

Patient's Signature_____ Date_____

-or-

- ○ I do not wish to have any of my health related information released to anyone other than myself.

Patient's Signature_____ Date_____

- ○ I give permission to leave messages in regards to blood work results, outside testing, appointment reminder, etc., either on my answering machine or with any individual who answers my home telephone.

Patient's Signature_____ Date_____

-or-

- ○ If I am unable to be reached by phone, no messages pertaining to myself are to be left on my home answering machine or with the individual that answers my home telephone.

Patient's Signature_____ Date_____

Any change of patient release information must be given in writing, verbal requests for changes will not be honored.