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AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

PATIENT NAME: _____, Patient DOB: _____
Please Print

In the event you must be contacted by phone with regards to test results, referrals or other medical information, please let us know how you prefer this to be done by marking one or all of the following that may apply:

_____ **Leave message on machine at home.**

_____ **Leave message with** _____ **at** _____
Name Telephone Number

_____ **Contact me at my work telephone number** _____
Telephone Number

_____ **You may discuss any of my medical information with the following emergency contacts:**

_____ **at** _____
Name **Telephone Number**

_____ **at** _____
Name **Telephone Number**

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Signature Date Date of Birth