Heartland Family First Medical Clinic

CONTACT AUTHORIZATION

Patient Name:	Date of Birth

Heartland Family First Medical Clinic is committed to protecting our patient's privacy. Without your authorization, messages left on voicemail or with other individuals will be limited. The only information left will be limited to our office name and phone number. If you prefer more complete information be provided, please fill out the form below.

Lab results will be communicated via patient portal

If we are needing to contact you by phone, please fill out the following:

Best daytime contact #:_____

☐ Leave **limited** message-only provider name and phone #
☐ Leave **detailed** message-lab/test results, med changes, etc.

Any written communication will go to the address on file.
Please verify we have your current address.

I hereby give permission to release my medical information to the following individuals (examples: spouse, children, sibling, friend, etc.). This includes but is not limited to lab or x-ray results, immunizations & injections, prescription medication information, surgical information, exam information, or treatment:

- _____
- _____
- _____

By signing below I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:**_____