Authorization for the Disclosure of Information

By completing this form, I authorize all SRCHC office staff, healthcare providers, and any agents or independent contractors acting at and under the direction of same to leave messages regarding appointments, test results, or diagnostic results on my answering machine/voicemail at the designated number(s), and/or with the designated family member/friend(s), and/or to disclose my health information to the designated family member/friend(s) as described below.

Please initial or mark as not applicable (N/A) all authorization(s):

_____ Authorization to **leave messages** concerning appointment information, test results or diagnostic results on the following answering machine/voicemail(s) or email.

_____, _____, _____, _____

(Home phone) (*Cell phone) (Message phone) (Email)

*Please circle: VOICE *TEXT*

1. Authorization to **leave messages** concerning appointment information with designated family member/friend(s). *Initial option 1, below.*

2. Authorization to **disclose my health information** to designated family member/friend(s). *Initial option 2, below.*

			1.	2.
(Name)	(Relationship)	(Phone number)	(Initial)	(Initial)
(Name)	(Relationship)	(Phone number)	(Initial)	(Initial)
(Name)	(Relationship)	(Phone number)	(Initial)	(Initial)
(Name)	(Relationship)	(Phone number)	(Initial)	(Initial)

_____ _____

Patient or Guardian/Personal Representative signature (circle one) **Date**

_____ _____

Printed name of Patient **Printed name of Signatory and relationship, if not Patient**

9/28/16