AUTHORIZATION FOR RELEASE OF INFORMATION

Our Practice contacts patients for a variety of reasons; including appointment reminders and providing test results. We **WILL NOT** leave detailed messages on an answering machine, voicemail or with anyone except the patient or legal guardian **UNLESS** we have your written permission to do so.

Please carefully consider the manner in which we may leave messages and whom you want to have access to your medical information.

Patient Name *(please print)* _____

I authorize the staff of Generations to leave detailed messages related to my medical care as indicated below:

- ☐ Leave detailed message on my **home** phone voice mail#_____
- ☐ Leave detailed message on my **cell** phone voice mail# _____
- ☐ Leave detailed message on my **office** phone voice mail #_____
- ☐ **DO NOT** leave detailed messages on any of my voicemails

I authorize the staff of Generations to release any medical information to the following people:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I understand that this authorization will remain in effect until revoked by me, in writing.

_____ _____

Patient/Legal Guardian Signature Date