THE FAMILY MEDICINE CLINIC

VERBAL RELEASE OF INFORMATION

TODAYS DATE_______________

PATIENT INFORMATION

NAME____________________________________BIRTHDATE______________________________________

Should it become necessary, may we contact you by text or email? YES____ NO______
Text Number______________________________ Email Address_______________________________________

I hereby allow The Family Medicine Clinic physicians and employees to discuss my medical information, such as appointment reminders, to verify dates and times of appointments, pick up prescriptions, verbal lab results, care or treatment needs, etc., with the following individuals:

(If you do not wish to list anyone's name, please write NONE on the first line.)

1. NAME__________________________________PHONE NUMBER______________________________

   RELATIONSHIP TO PATIENT____

2. NAME__________________________________PHONE NUMBER______________________________

   RELATIONSHIP TO PATIENT____

Can we leave messages on your answering machine/voicemail? __________yes _________________no

My signature below indicates that I understand the following:

I may change the names of the individuals listed above at any time. Changes must be made in writing. I understand that this release DOES NOT include receiving paper copies from my medical record and/or receiving medical information without due cause. In order to receive that information a HIPPA compliant records release signed by the patient is required.

SIGNATURE OF PATIENT____
DATE____
I acknowledge that I understand The Family Medicine Clinic's Notice of Privacy Practices. I am aware that I may ask for a printed copy of these practices at any time and that they are posted in a common and noticeable area in the practice.

Initial__________ Date__________