

Any information related to my medical care is considered confidential and will not be released to anyone without my permission. I hereby give permission for any medical information related to my treatment to be given to:

Name _____ Relationship _____

Phone _____

Name _____ Relationship _____

Phone _____

THIS OFFICE MAY: (CHECK ALL THAT APPLY)

_____ leave test results on your cell phone (number) _____

_____ send test results via e-mail: E-MAIL address _____

_____ leave a message at work to call the office (work number) _____

_____ leave a message on my home answering machine to call the office

_____ leave test results on answering machine

_____ call me at work with results (number) _____

_____ send medical information to any healthcare provider I am referred to (lab, physicians, etc)

_____ none of the above

PRINT PATIENT NAME: _____

**PATIENT OR LEGAL
GUARDIAN SIGNATURE** _____ **DATE** _____