# Permission for Disclosure of Medical Information

(Please print clearly)

Today's Date: ____________________________

LAST NAME: ______________________ FIRST NAME:______________________ DATE OF BIRTH: ______________

**PREFERRED METHOD** TO **CONTACT YOU:** HOME WORK CELL OTHER: ________________________________

HOME **PHONE:**_____________________WORK PHONE:______________________CELL PHONE: _______________________

To protect your privacy, please help us know the contact person(s) you allow us to talk to. Please list your emergency contact first. **If this is a minor child, please provide the names and information of all parents and guardians.**

| NAME | PHONE NUMBER | RELATIONSHIP |
|---|---|---|
| Emergency Contact: | | |
| | | |
| | | |

Can we leave a message on an answering machine: YES NO

Can we leave a message with a person who answers the phone: YES NO

List any information that you do not want released or person(s) to whom you do not want us to give your information:

If this is a minor child, is anyone not allowed to access the child's records or information? YES NO
If yes is circled, please specify below and provide a copy of the court order specifying such.

Patient, Parent or Legal Guardian Signature:_____________________________________Date:______________

☐ Reviewed with no changes Signature: ________________________________________ Date: ____________

☐ Reviewed with no changes Signature: ________________________________________ Date: ____________

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