AUTHORIZATION FOR
TELEPHONE CONTACT AND SHARING OF INFORMATION

PATIENT NAME______________________________________**DATE OF BIRTH**______________

May we contact you by telephone at HOME? **YES** **NO**

If you have an answering machine at home, may we leave messages regarding test results, medications, appointment, or billing matters? **YES** **NO**

If you are not at home, may we leave message for you regarding test results, medications, appointments, or billing matters with another person? **YES** **NO**

May we contact you by telephone at your WORKPLACE **YES** **NO**

If you have voice mail at your workplace, may we leave messages to return the call to our office. **YES** **NO**

If you are not available at your workplace, may we leave messages to return the call to our office with whomever answers your phone? **YES** **NO**

YOU MAY AUTHORIZE US TO SHARE YOUR MEDICAL INFORMATION WITH OTHERS. (EXAMPLE: DISCUSS CARE OF STUDENTS AWAY AT SCHOOL, WITH YOUR SPOUSE, OR WITH CHILDREN OF ADULTS WHO NEED ASSISTANCE.)

I give physicians and staff of **Mound Family Practice Associates, Inc.** to speak with the following person(s) and share my medical care/information.

Name____**Relationship**_________________

Name____**Relationship**_________________

Name____**Relationship**_________________

Name____**Relationship**_________________

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Patient/Guardian Signature **Date**