Pacific Family Medicine, LLP

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AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I,____ ◻ DO ◻ DO NOT
(Patient or Guardian, if Minor)
wish to name a representative to act on my behalf for my medical care.

Representative

Name____________________________ Relationship______________________________

Date of birth______________________ Phone(s)__________________________________

Name____________________________ Relationship______________________________

Date of birth______________________ Phone(s)__________________________________

Name____________________________ Relationship______________________________

Date of birth______________________ Phone(s)__________________________________

There may be times when the PFM staff may need to contact you regarding appointments, test results or other communications. In order to contact you, we need authorization to leave you a message.
(By checking the following box, you authorize & allow us to leave a message.)

◻ I give permission for PFM staff to leave a message on my home &/or cell answering machine or voice mail. Phone/Cell #'s:____

Signature____ Date_______________________

Relationship if other than patient signing form_____________________________________