AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION

Patient Name ______________________________________ Date of Birth ______________________

1) **Please check (√) one only:**

☐ I only want my medical information released to myself.

☐ I give Tamar K. Gottfried, M.D. and staff authority to release medical information regarding my care to the following individuals:

Individuals Name	**Relationship to Patient**

2) **Emergency Contact Name** ______________________________________

Emergency Contact Phone Number ______________________________________

3) **Please Initial below:**

_____ Yes, I give my permission to leave messages regarding my test results, appointments, etc., at the following phone numbers _______________, _______________________.

_____ No, do not leave messages regarding my test results, appointments, etc.

Patient Signature ___________________________ Date ______________________________

Witness ____

NOTE: The above authorization remains effective until patient notifies practice in writing of any change.

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FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgment of receipt of this **AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION** but could not because:

☐ Individual refused to sign ☐ Communication barrier ☐ Care provided was emergent ☐ Other:____________

Employee Name ______________________________________ Date ______________________