



Authorization to Release Patient Information

Patient Information			
Patient Name:	DOB:	Phone:	
Authorization to Release Patient Information			
I, _____, give my permission to the Adair County Medical Clinic personnel to leave a message concerning protect health information by the following methods:			
Leave a message on answering machine/voice mail (results, appointments, and health information)			
<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell			
If you are unavailable may we leave message with:	Name:		Phone:
	Name:		Phone:
	Name:		Phone:
Send a letter.			
Other (Specify):			
Signature	Relationship to Patient	Date	