ENCOMPASS MEDICAL GROUP

Authorization To Release Protected Health Information

Medical Record Number_____

Patient Name_____ Date of Birth _____

Home Phone_____ Work Phone_____

Cell Phone_____ Other_____

I give my permission for my medical information (e.g. lab results, biopsy results, etc.) to be released to the following people:

#1

_____ _____

Name Relationship

_____ _____ _____

Home Phone Cell Phone Work Phone

#2

_____ _____

Name Relationship

_____ _____ _____

Home Phone Cell Phone Work Phone

#3

_____ _____

Name Relationship

_____ _____ _____

Home Phone Cell Phone Work Phone

Check here if you do not want your information discussed with anyone but yourself.

☐ Discuss with me only ☐ Ok to discuss with others above

Results may be left on my home or cell phone voicemail. ☐ Yes ☐ No

_____ _____

Patient Signature **Date**