McDonagh Medical Center

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Nutrition · Allergies · Family Practice · Degenerative Diseases · Preventative Medicine · Metabolic Disorders · Prolotherapy

RELEASE OF INFORMATION

Due to patient confidentiality concerns, McDonagh Medical Center would like to know to who we have permission to release information regarding your appointments, care, bills and test results.

Patient Name: _____Date of Birth: _____

I give permission for McDonagh Medical Center to release my information to:

1. _____

Relationship: _____ Phone: _____

2. _____

Relationship: _____ Phone: _____

3. _____

Relationship: _____ Phone: _____

4. _____

Relationship: _____ Phone: _____

5. _____

Relationship: _____ Phone: _____

I do **NOT** wish to have any information released to anyone other than myself

Signature: _____

This message is valid for all test results unless we are otherwise notified in writing not to release any information to someone other than myself.

Messages may be left on an answering machine or voicemail as long as we are sure that it is a correct number. If you circle NO, the results may be mailed to you if we cannot reach you by phone.

YES **NO**

Signature: _____Date: _____