Patient Contact information

Home Phone ____________________________________

Work Phone ____________________________________

Cell Phone ____________________________________

Email ____________________________________

Are we permitted to give appointment information to family members?

YES NO (Please Circle One)

If Yes, Please list family members we may release results:

________________________ ________________________

________________________ ________________________

Are we permitted to leave a detailed message with appointment information on voice mail?

YES NO (Please Circle One)

DURATION:

This authorization will remain valid for one-year from today's date or at an earlier date, at my election. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Occupational Health. I understand the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Patient Name (Please Print): ________________________________**DOB** ______________

Patient Signature: ____

Date: ________________ **Time:** ________________