Albany Family Medicine

John W. Carter, M.D.

Authorization to Release Confidential Information to Other Persons and/or Leave Messages

Patient Name: _____

Date of Birth: _____

You have a right to privacy and we will not release confidential information about you unless it is for patient care and treatment, or authorized in other consents such as consents for billing

We want to be able to provide you with information about your care but we also want to honor your requests regarding how you would like us to communicated with you

Please complete the following questions.

Home:

We can call you at home	☐Yes	☐No
We can leave a message on your answering machine	☐Yes	☐No

Work:

We can call you at work	☐Yes	☐No
We can leave a message on your voicemail	☐Yes	☐No

Other:

We can call you on your cell phone	☐Yes	☐No
We can page you	☐Yes	☐No
We can fax information about you to other medical offices that may be providing care to you.	☐Yes	☐No

Do you have someone with whom you would like us to be able to share confidential patient information about you?

Name (s)	Relationship to You (Spouse, Parent, Friend, Neighbor)	Telephone

I _____ do _____ do not acknowledge and agree that I have received the Notice of Privacy Practices.

I authorize _____ to release information about me as signified above. This authorization may be changed by me at any time.

_____ _____

Patient (or Legal Represenative) Signature Witness Signature

_____ _____

Date Date