MORGAN FAMILY MEDICINE

Authorization to release information

Patient Name: _____ DOB: _____

Preferred Name: _____ Preferred Pronouns: she/her he/him they/their

I hereby authorize confidential communications from the physicians or staff of Morgan Family Medicine regarding my health, care, treatments, appointments, prescriptions, etc. to be received at any of the numbers given below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers;

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Other: _____

I authorize the following individuals to call the office on my behalf to verify the status or appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions or samples that I have requested:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand this authorization will remain in effect until I revoke the authorization in writing.

_____ _____

Patient Signature Date