Estelle Archer MD
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Amarillo, TX 79106
806-350-7312

PATIENT HIPPA INFORMATION

Patient Name: _____ (Please Print)
I hereby authorize the Doctor and/or the nurse to leave lab and/or radiology results and other messages pertaining to my healthcare on my message machine or voice mail at this number

_____.

Also the message may be left with _____.

Initial: _____

Date: _____

I, _____ authorize the release of my medical records to Physicians to whom I am referred or to medical health facilities in which I have received or will receive, medical services.

Initial: _____

Date: _____

I, _____ authorize

_____
(Full Name) (Telephone) (Relationship)
to receive any of my personal medical information from Dr Archer's office. I understand this authorization is in effect until I write a letter revoking this authorization.

Initial: _____

Date: _____