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## AUTHORIZATION TO RELEASE INFORMATION

IN THE EVENT THAT WE ARE UNABLE TO REACH YOU TO RELAY ANY RESULTS FROM YOUR OFFICE VISIT, MAMMO, OR SONO REPORTS.

PLEASE FILL OUT THE FOLLOWING IF YOU WANT TO GIVE US PERMISSION TO RELEASE THIS INFORMATION TO ANOTHER INDIVIDUAL:

### YOU HAVE MY PERMISSION TO GIVE TEST RESULTS TO:

(Please check all that apply.)

\_\_\_ My Spouse \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_ My Parent (Mother) \_\_\_\_\_ Phone \_\_\_\_\_

(Father) \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_ Other \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_ **ONLY GIVE MY TEST RESULTS TO ME**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## REGARDING FAX TRANSMISSIONS OF PATIENT INFORMATION:

I AUTHORIZE THIS OFFICE TO USE FACSIMILE (FAX) AS A MEANS OF QUICK COMMUNICATION WITH OTHER PHYSICIAN'S OFFICES, MEDICAL FACILITIES, AND/ OR INSURANCE COMPANIES FOR INFORMATION THAT PERTAINS TO MY CARE. I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Patient Name or Legal Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

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