PATIENT RELEASE OF INFORMATION - TO FAMILY MEMBERS & DEVICES

Fisher's Landing Primary Care

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I hereby authorize the release of information concerning my medical history, diagnosis, treatment, prognosis and recommendations, as well as other pertinent data regarding my healthcare and/or upcoming appointments to:

Please check all that apply, indicate if we may leave a detailed voicemail by circling Y for YES or N for NO, then sign and date below:

Home Phone Answering Machine/Service	_____	Y N
Cell Phone Voicemail	_____	Y N
Work Phone	_____	Y N
Message Phone	_____	Y N
Email Address	_____	Y N
Other (please specify below)	_____	Y N

Other Family Member(s)

If Authorizing, please specify Spouse/Partner/Other Contact Information below:

Name: _____ Relationship to Patient_____

Contact Number: _____ Can we leave a detailed Voicemail: Y N

Name: _____ Relationship to Patient_____

Contact Number: _____ Can we leave a detailed Voicemail: Y N

SIGNATURE: _____ DATE: _____