PLUMSTEADVILLE FAMILY PRACTICE

Authorization to Communicate Personal Medical Information

Patient Name_____ Date of Birth_____
Emergency Contact Name _____
Emergency Contact Phone Number_____
Relationship to Emergency Contact_____

We are unable to discuss your medical information with anyone unless you give us written permission.

( ) I authorize the release of my medical information including diagnoses, records, images, examinations rendered to me as well as claims information. This information may be released to:

( ) My Emergency Contact Above

( ) Spouse Name and Phone Number _____

( ) Child(ren) Name(s) and Phone Number _____

( ) Parent Name and Phone Number _____

( ) Other Name and Phone Number _____

OR

( ) Only to myself

This release of information will remain in effect until terminated by me in writing.

Signature _____ Date signed _____