Patient Authorization for Disclosure/Release of Information

Patient Name ______________________________________ Date of Birth ________________________

Address ____

I request that the communication regarding my protected health information be given to me, other than verbally and in person, by calling the following phone number(s):

HOME PHONE (______) - ________ - _________

☐ Yes, a message can be left at this phone number

☐ No, a message cannot be left at this phone number

WORK PHONE (______) - ________ - _________

☐ Yes, a message can be left at this phone number

☐ No, a message cannot be left at this phone number

CELL PHONE (______) - ________ - _________

☐ Yes, a message can be left at this phone number

☐ No, a message cannot be left at this phone number

I understand that Mirabile M.D. may choose not to leave a message

My information may be told to the following individuals

Name ____ Relationship ____________________________________

Name ____ Relationship ____________________________________

This request will be kept in place at all times until I revoke this request at any time in writing, and submit another request to Mirabile M.D.

Patient Signature ____ Date _____________

Signature of personal representative of patient and/or description of representative's authority to act for patient:

____ Date ________________