PERMISSION TO DISCLOSE PERSONAL MEDICAL INFORMATION

Please provide us with the telephone number you would like us to use when contacting you with regard to medical records, such as test results, treatment options, etc.

Patient Name:_____ **Date of Birth:**_____

Primary Phone Number:_____ **Secondary Phone:**_____

Voice Mail Messages: (check one)

- O Confidential information may not be left on voice mail.
- O I give permission for Dr. Hutchins and staff to leave messages, with discretion, on voice mail for the numbers listed above.

Disclosure to Other Persons: (check one)

- O Any information regarding my health record or treatment options may only be discussed with me.
- O I give permission for Dr. Hutchins and staff to disclose health information to the following people:

1. _____ Relationship _____Phone:_____
2. _____ Relationship _____Phone:_____
3. _____ Relationship _____Phone:_____

_____ _____

Signature Date