AUTHORIZATION TO COMMUNICATE HEALTH INFORMATION

Patient Name: Date of Birth: / /

PHONE AUTHORIZATION:

☐ Yes, you have my permission to leave medical information on my voice mail. Please list which daytime telephone number is best to leave a message.

( ) _____

☐ No, you do not have my permission to leave medical information on my voicemail.

CONTACT AUTHORIZATION:

To whom, other than yourself, may we speak with regarding your medical information?

Name: Relationship:

Contact Phone Number:

Name: Relationship:

Contact Phone Number:

☐ I elect **NOT** to have any of my medical information shared at this time.

Signature: Date: / /

This authorization will be effective for 1 year and utilized for all Virtua Medical Group service lines. I have the right to withdraw or revise my permission at any time in writing.