FGA | FREDERICK GASTROENTEROLOGY ASSOCIATES

Authorization for Verbal communication and/or Voice Mail messages

Patient's Name____
Please Print

Information to be disclosed by Voice Mail.

☐ I give permission for my medical information to be left on my telephone numbers listed below:

☐ Cell___________________ ☐ Home___________________ ☐ Work___________________

☐ I do not give permission for voice mail disclosure of my medical information.

Information to be disclosed by Verbal Communication.

☐ I authorize verbal disclosure of medical information be made to:

(Person's Name)____
Please Print Relationship Telephone number

(Person's Name)____
Please Print Relationship Telephone number

(Person's Name)____
Please Print Relationship Telephone number

☐ I do not give permission for verbal disclosure of my medical information.

I understand that the medical information released may contain information related to Hepatitis, HIV status, AIDS, Sexually Transmitted Diseases, Alcohol or Drug use, or Mental Health Services; and hereby authorize the release of this information. ***I may withdraw this authorization at any time except to the extent that action has been taken in response thereon.***

________________________ ____________ / / ______ ____ ______
Signature of Patient Date Signed Date of Birth Social Security No.

______________________ ______________________ ______________________________
Witness Name Witness Signature Date