



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