

Authorization to Release Medical Information

Patient Name: _____

I authorize the following to have access to my medical records. (Check all that apply)

- My Spouse _____
Name of Spouse
- My Child _____
Name of child
- My Representative _____
Name of Representative
- Other _____
Name of Other Person

I also give permission for my physician to give test results and discuss my medical condition with the above named person/persons.

Yes No
Check One

I authorize Southern Family Medicine, LLC doctors or personnel to leave messages regarding blood work results or other tests on my home answering machine or via e-mail.

Yes No
Check One

Who may we contact in case of an emergency?

Name _____ *Phone:* _____

E-mail address

Phone Number

Signature

Printed Name / Relationship to Patient

Witness

Date

The doctors and staff of Southern Family Medicine, LLC will follow the above directions until notified in writing of a change.