

Authorization to Release Patient Information

Patient Name: _____ **DOB:** _____ **Phone:** _____

I give my permission to the Adair County Medical Clinic personnel to contact me concerning protected health information by the following methods:

Leave a message on an answering machine- **Circle one: Home Cell N/A**

Talk with or leave a message with the following people-

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature: _____ Date: _____

If the patient is a minor, please complete the following:

Primary Guardian: _____ Phone: _____

Secondary Guardian: _____ Phone: _____

If you are unavailable to bring the minor to an appointment, please list names of people who are approved to bring the minor in.

Note- the parent or guardian may still be held responsible for any charges that result from the visit. If the minor may come alone, please list their name below.

Name: _____

Name: _____

Name: _____