AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____ authorize Walton Family Medicine, P.C. to:
(patient or legal guardian if patient is a minor)

(mark all that apply)
_☐_ release my test results
_☐_ release medication(s) I have requested
_☐_ release written prescriptions, copies of forms or records that I have requested
_☑_ release information concerning appointments and referrals

to the following people:

_____
(list any and all names)

OR

I, _____ **DO NOT** authorize anyone other than myself
(patient or legal guardian if patient is a minor)
to receive any of my medical information.

I _☑_ DO _☑_ DO NOT authorize you to leave messages on my home answering machine regarding appointments and referrals or to inform me that test results are available. (You must call the office to get test results; they are never left on the answering machine.)

I _☐_ DO _☑_ DO NOT authorize you to contact me or leave messages at my place of work.

I understand that this authorization shall remain in effect until revoked by me in writing and that I may amend this agreement at any time.

_____
PRINT NAME

_____ Date: _____
SIGNATURE