FRANCONIA FAMILY MEDICINE, P.C.

Authorization for Verbal Release of Patient Information

I, ___________________________hereby authorize the doctors and staff of Franconia Family Medicine, P.C. to release any and all information pertaining to my health care, test results, procedures, billing and/or accounting information to the following person(s) or agencies.

___ Spouse ___ Other______________________

___ Parents ___ SELF ONLY

I further authorize the doctors and staff to dispense results of my medical exams in one or more of the following ways:

May leave a message to return call to physician's office:

___ At home ___ At work ___ On cell phone

___ On answering machine at home ___ On voice mail at work

May leave type of test and test results:

___ On answering machine at home ___ On voice mail at work ___ On cell phone

I understand that this office will release any information to those persons whom I have determined may receive this information without separate consent. In addition, I understand that this relates to all medical as well as billing information. **This will be actively enforced**. **If you wish to change the status of this form, you must do so in writing.**

______________________________ ______________ ________________________________

Patient Signature Date Authorized Witness

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