

FAMILY DOCTORS OF GREEN VALLEY

**Due to HIPAA (Health Information Portability & Accountability Act)
we have had difficulties contacting patients.
By filling out and signing below, you are authorizing the
release of medical information.**

Date: _____
Patient Name: _____
Date of Birth: _____
Social Security #: _____

Check all that apply:

I authorize my medical information to be released to the following person (s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

When calling to release test results, what is the **BEST** number to contact you?

_____	_____
Daytime Phone Number	Evening Phone Number

And in the event you are unable to be reached, may we leave a message?

Yes No

Authorizing medical information and/or newsletters pertaining to the practice to be released by e-mail.

E-Mail Address

Patient Name (Please Print)

Patient Signature

NOTE: In the event that we are unable to contact you by either phone or e-mail, after several attempts your results will be mailed to you. If you have any questions, please contact the Nursing Department at (702) 616-9471.