2019

AUTHORIZATION TO RELEASE MY MEDICAL CARE

I _____ give Primary Care Physicians of Gainesville permission to discuss my medical care and account information with the following person(s):

Name of authorized person	Relation	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

You may leave detailed messages regarding my healthcare (not including lab results) on my:

☐Cell Phone ☐ Home Phone ☐ Neither

You may leave messages regarding my lab results on my:

☐Cell Phone ☐ Home Phone ☐ Neither

_____ _____

Signature of Patient Date

_____

Printed Name of Patient