ALL CARE CLINICS

PATIENT AUTHORIZATION FOR MEDICAL DISCLOSURE
OVER THE TELEPHONE OR FAX

Please Fill out the form and give back to the Front Desk.

The patient authorizes this clinic to disclose medical information regarding clinical care and diagnosis including lab results and medical history to those listed below.
i.e. Referring Physician, Family Physician, Family members, Attorney

1. **Primary Care Physician** _____
Telephone: _____

2. Name: _____
Telephone: _____
Relationship: _____

3. Name: _____
Telephone: _____
Relationship: _____

4. Name: _____
Telephone: _____
Relationship: _____

5. Name: _____
Telephone: _____
Relationship: _____

This consent is in effect until revoked in writing. Our office requires patient consent in writing for all information request not related to billing requirements.

_____ _____
Name of the Patient Date

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient