LEVITTOWN
Family Medicine

Release of Medical Information

Section A:

I, _____, give Levittown Family Medicine permission to leave information on my answering/voice mail or with the following member(s), or designated representative(s) as noted below.

Answering/voice mail at the following number(s): _____

_____ Or:

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Please initial all that can be left on the above answering/voice mail or with the above representative(s):

_____Test Results

_____ Lab Results

_____ Medication Changes

_____ Prescription Information

_____ Billing/Insurance Inquiries

_____ Confirming Appointments

_____ Any information pertaining to all aspects of my medical care including all of the above.

Signature: _____ Date: _____

Relationship to patient (if minor or signed by personal representative): _____

Section B:

I, _____, do not want my information pertaining to all aspects of medical care left on my answering/voice mail or with anyone other than myself.

I understand that I may revoke/amend this authorization at any time as long as it is in writing.

Signature: _____ Date: _____

Relationship to patient (if minor or signed by personal representative): _____