MONTGOMERY FAMILY MEDICINE, P.C.
8190 Seaton Pl ◆ PO Box 240369
Montgomery, AL 36124

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I _____, do hereby grant authorization to release information on my behalf regarding my treatment and condition to the following:

Name _____ Spouse / Others

Name _____ Children / Parent / Guardian

To me at my home phone number _____

To me at my work phone number _____

To me at my cell phone number _____

And to any telephone answering machine or voice mail at the above numbers.

My e-mail is _____ and appointment reminders, general health alerts and notices may be sent to my e-mail. I understand test results or personal clinical information will NOT be sent via e-mail.

I will confirm my address at every visit and Montgomery Family Medicine may mail information there.

My phone numbers are correct and I can be contacted at any number (including cell) I provide here or in the future by any employee or agent of Montgomery Family Medicine for any purpose related to treatment, payment or other healthcare operations

It is my responsibility to make Montgomery Family Medicine aware of any changes to this authorization. This authorization is in effect as long as I am a patient or until rescinded by me.

Patient Signature_____ Date *_____

* The latest dated consent supersedes all others

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"I **revoke** *my prior consent."* _____ *Staff witness:* _____

Signature Date