MIDWEST PERINATAL ASSOCIATES

PERMISSION TO SPEAK WITH ANOTHER PARTY REGARDING APPOINTMENT, LAB RESULTS, MEDICAL RECORDS, AND/OR CHARGES

Patient's Name: _____ DOB: _____

☐ **Home/Cell: leave message regarding appt/lab results**
- ☐ on answering machine
- ☐ with anyone who answers home phone
- ☐ only with _____ (Name)
- ☐ contact patient only
- ☐ text/email appointment reminders (we will not text/email lab results)

☐ **Office:** Leave message regarding appt/lab results
- ☐ on voice mail
- ☐ with anyone who answers work phone
- ☐ only with _____ (Name)
- ☐ contact patient only

☐ Other: _____ Phone: _____

☐ Cell Phone:

MEDICAL RECORDS

I hereby authorize you to discuss my medical treatment with another party **EXCLUDING MY REFERRING PHYSCIAN**:

_____ Phone: _____
(Person or Party you are permitting to receive information)

_____ Phone: _____
(Person or Party you are permitting to receive information)

☐ **DO NOT RELEASE OR DISCUSS MEDICAL TREATMENT WITH ANYONE OTHER THAN PATIENT AND/OR RESPONSIBLE PARTY.**

ACCOUNT INFORMATION

I hereby give permission for the following individuals to discuss my billing/account information **EXCLUDING MY INS.CO.**

_____ Phone: _____
(Person or Party you are permitting to receive information)

_____ Phone: _____
(Person or Party you are permitting to receive information)

☐ **DO NOT RELEASE OR DISCUSS BILLING/ACCOUNT INFORMATION WITH ANYONE OTHER THAN PATIENT AND/OR RESPONSIBLE PARTY.**

_____ _____
Signature of Patient or Responsible Party Date