

BALCONES WOODS FAMILY MEDICINE

Acknowledgement of Review of Notice of Privacy Practices

RELEASE OF INFORMATION

I authorize Balcones Woods Family Medicine to leave detailed messages regarding my lab results and health care on my home answering machine or voicemail. Please list preferred number to confirm: (____) _____ - _____.

OR

NO, please do not leave messages with any medical details (such as lab results) on my answering machine/voicemail.

I authorize Balcones Woods Family Medicine to e-mail me medical information as discussed above. Please list your preferred e-mail address: _____.

OR

NO, please do not e-mail me medical information.

_____ I hereby release Balcones Woods Family Medicine to furnish medical or other information concerning
INITIAL my present illness or injury to other physicians involved with my care or treatment, Medicare or insurance companies.

_____ I further authorize any other doctors or other care providers to furnish any and all information
INITIAL concerning my present illness or injury to Balcones Woods Family Medicine.

_____ I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF AN ORIGINAL.
INITIAL

_____ I give Balcones Woods Family Medicine permission to release information regarding my healthcare,
INITIAL including, but not limited to, appointment information, test results, diagnosis, etc., whether in written, oral, and/or electronic format to the following individuals (please include contact information):

I have reviewed Balcones Woods Family Medicine's Notice of Privacy Practices (copy available at front desk), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Printed Name of Patient or Personal Representative

Date

Signature of Patient or Personal Representative

Description of Personal Representative's Authority
(Indicate self, or if patient is a minor or unable to sign write parent, etc.)