Health Partners LLC

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COMMUNICATION RELEASE FORM

I hereby give permission to the office staff at Health Partners LLC to notify me by telephone of the following: (check all that apply)

Yes_____ No____ Appointment reminder, either by personal message or recorded message.

Yes_____ No_____ A message to call the office for test results

Yes_____ No_____ Talk to anyone listed below regarding my health condition, test results (normal or abnormal), and medical history.

The individual(s) listed below are authorized to receive the above information on my behalf:

____

I understand this form is intended to guard my privacy and is a release of general medical information.

________________________________ ____________________
Patient Signature (Responsible Party)   Date

____ ____________________
Witness Signature   Date