ADVANCED
ADULT CLINIC

CONTACT AUTHORIZATION

I authorize Advanced Adult Clinic, Inc to leave voice messages regarding confidential medical information by the following method (please check below):

☐ Home phone _____ ☐ Work Phone _____ ☐ Cell Phone _____

I authorize Advanced Adult Clinic, Inc to release any information regarding my treatment; including lab results, x-rays, and prescriptions, to the following named individuals and or entities. If you don't want to designate anyone, please check box below.

Name _____ Relationship to Patient _____ Contact Info _____

Name _____ Relationship to Patient _____ Contact Info _____

Name _____ Relationship to Patient _____ Contact Info _____

☐ I do not want my health information discussed with anyone other than myself.

I understand that I can make changes or revoke authorization at anytime by putting a request in writing and will take effect upon receipt of such request by the clinic staff or physician.

_____ _____

Name and Signature of Patient or Representative Date