considers p protected, p	atient confidentiality to bolease read and sign the	e of utmost importar	f <i>Provider/Clinic)</i> nce and concern. Ir rm.	n an effort to	o ensure t	that your pri	vacy is
		AUTH	ORIZATION				
I authorize t all that appl	the provider/clinic to leav ly):	e a message on my	home answering n	nachine per	taining to	the followin	ıg (chec
	Date and time of upcoming Laboratory results (e.g., laboratory CT scan, MRI or o	blood tests, Pap smea		res)			72
	Reminder to schedule remaintenance exam, color Referral information (app Other (please list):	curring screening serv	ices or testing (e.g., n pidoscopy)		, PSA, Pap	o, annual hea	lth
I authorize t following <i>(cl</i>	the provider/clinic to leave heck all that apply):	e a message on my	work voicemail or	answering	machine p	pertaining to	the
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authorizatio	d that this authorization we have a second that by a members of my family a	giving my consent, ir	nformation about my	y personal l	nealth car	e could be r	made
Signed:				Date:			
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		AUTHORIZA	ATION REVOKED				
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Patient Name: