Buffalo Trace Gastroenterology

I HEREBY AUTHORIZE THE PHYSICIAN AND STAFF TO GIVE THE FOLLOWING PEOPLE
INFORMATION CONCERNING MY HEALTH RECORD:

_____SPOUSE
NAME:_____
PHONE #_____

_____OTHER
NAME:_____
PHONE #_____

PLEASE MARK (x) THE FOLLOWING INFORMATION THAT MAY BE GIVEN TO THE ABOVE
AUTHORIZED PERSON(S):

_____APPT TIME
_____MEDICATIONS
_____ANY INFORMATION REGARDING MY HEALTH
_____INFORMATION REGARDING INSURANCE/BILLING
_____TEST/LAB RESULTS
_____PROCEDURE INFORMATION

_____I GIVE PERMISSION TO LEAVE A MESSAGE ON THE ANSWERING MACHINE REGARDING ANY OF THE ABOVE.

_____ _____
Patient Signature Date