CR MEDICAL GROUP

PARTNERS IN YOUR HEALTHCARE FOR LIFE

Patient Name: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please answer the questions below:

Can we leave messages at your home/cell: □ Yes □ No

Can we contact you at work? □ Yes □ No

**IF we are authorized to give information to anyone <u>OTHER THAN PATIENT</u> please fill out the section below.*
I am giving my authorization to release medical information/appointment dates/times to:

Name: _____ Phone#: _____

Relationship: _____

Password (For example: patient's mother's maiden name):_____
Note: This password must be provided to the office to ensure we are speaking to the authorized person. Information will not be released if the password is not provided.

The patient can make changes to this authorization form at any time. The patient must complete a new form in the office.

Patient Signature: _____ Date: _____

Witness (office staff): _____