

McDONAGH MEDICAL CENTER

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E.W. McDonagh, D.O., ACPG Charles J. Rudolph, D.O., Ph.D

Nutrition Allergies Family Practice Degenerative Disease Preventive Medicine Metabolic Disorders

Release of Information

Due to Patient Confidentiality concerns, McDonagh Medical Center, would like to know to who we have permission to release information regarding your appointments, care, bills, and test results. This consent is good for one calendar year.

PATIENT NAME: _____ Date of Birth: _____

I give permission for McDonagh Medical Center, to release my information to:

1. _____

Relationship: _____ Phone: _____

2. _____

Relationship: _____ Phone: _____

3. _____

Relationship: _____ Phone: _____

4. _____

Relationship: _____ Phone: _____

5. _____

Relationship: _____ Phone: _____

I do NOT wish to have any information released to anyone other than myself

Signature: _____

This consent is valid for all test results unless we are otherwise notified in writing not to release any information to someone other than myself

Messages may be left on an answering mach at home as long as we are sure that it is the correct number. If you circle NO, the results may be mailed to you if we can not reach you by phone.

YES

NO

Signature: _____ Date: _____