PORTER PHYSICIANS SERVICES, LLC

Department Name _____

PRIVACY DISCLOSURE INFORMATION AUTHORIZATION

I, _____, have been offered or received the Privacy Notice for Porter and signed the authorization for the following:

Please list below whom we can speak with and release information to:
(Please understand a Medical Records release will need to be signed)

Family or Friend Name	Relationship to the Patient	Phone Number	Leave Messages and Speak with:	Review Your account with:	Ok to Pick up prescriptions, orders and Medical Records:

I allow messages to be left on the telephone number I provided on the patient information form. ___ Yes ___ No

Signature _____Date_____

Relationship to the Patient: _____

Refusal of above _____Date _____