FGA | FREDERICK GASTROENTEROLOGY ASSOCIATES FEC | FREDERICK ENDOSCOPY CENTER

Authorization for Verbal communication and/or Voice Mail messages

This form will provide authorization to both:

Frederick Gastroenterology Associates and Frederick Endoscopy Center

Patient's Name_____
Please Print

Information to be disclosed by Voice Mail.

☐ I give permission for my medical information to be left on my telephone numbers listed below:

Cell _____ Home _____ Work _____

☐ I do not give permission for voice mail disclosure of my medical information.

Information to be disclosed by Verbal Communication.

☐ I authorize verbal disclosure of medical information be made to:

(Person's Name)_____
Please Print Relationship Telephone number ☐ Cell ☐ Home ☐ Work

(Person's Name)_____
Please Print Relationship Telephone number ☐ Cell ☐ Home ☐ Work

(Person's Name)_____
Please Print Relationship Telephone number ☐ Cell ☐ Home ☐ Work

☐ I do not give permission for verbal disclosure of my medical information.

EMERGENCY CONTACT
Person to notify in case of an emergency:
Name _____ Relationship to Patient:_____

Cell _____ Home _____ Work _____

I understand that the medical information released may contain information related to Hepatitis, HIV status, AIDS, Sexually Transmitted Diseases, Alcohol or Drug use, or Mental Health Services; and hereby authorize the release of this information. ***I may withdraw this authorization at any time except to the extent that action has been taken in response thereon.***

_____ _____ __/__/____ _____ ____ _____
Signature of Patient Date Signed Date of Birth Social Security No.

_____ _____ _____
Witness Name Witness Signature Date