

MIDWEST PERINATAL ASSOCIATES

PERMISSION TO SPEAK WITH ANOTHER PARTY
REGARDING APPOINTMENT, LAB RESULTS, MEDICAL RECORDS, AND/OR CHARGES

Patient's Name: _____ DOB: _____

<input type="checkbox"/> Home: Leave message regarding appt/lab results <input type="checkbox"/> on answering machine <input type="checkbox"/> with anyone who answers home phone <input type="checkbox"/> only with _____ (Name) <input type="checkbox"/> contact patient only	<input type="checkbox"/> Office: Leave message regarding appt/lab results <input type="checkbox"/> on voice mail <input type="checkbox"/> with anyone who answers work phone <input type="checkbox"/> only with _____ (Name) <input type="checkbox"/> contact patient only
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Other: _____ Phone: _____

Cell Phone: _____

MEDICAL RECORDS

I hereby authorize you to discuss my medical treatment with another party **EXCLUDING MY REFERRING PHYSICIAN:**

(Person or Party you are permitting to receive information) Phone: _____

(Person or Party you are permitting to receive information) Phone: _____

DO NOT RELEASE OR DISCUSS MEDICAL TREATMENT WITH ANYONE OTHER THAN PATIENT AND/OR RESPONSIBLE PARTY.

ACCOUNT INFORMATION

I hereby give permission for the following individuals to discuss my billing/account information **EXCLUDING MY INS.CO.**

(Person or Party you are permitting to receive information) Phone: _____

(Person or Party you are permitting to receive information) Phone: _____

DO NOT RELEASE OR DISCUSS BILLING/ACCOUNT INFORMATION WITH ANYONE OTHER THAN PATIENT AND/OR RESPONSIBLE PARTY.

Signature of Patient or Responsible Party

Date