MegMed Health, LLC

Authorization to Leave Message and Disclose Healthcare Information

Patient Name _____ Date of Birth_____/_____/_____

Which of the following ways of communication are acceptable for MegMed to communicate with you:

(Please check all that apply)

___Home or Cell Number Okay to leave a message? Yes or No

___Email address Okay to send a message? Yes or No

Authorization to Disclose Healthcare Information

Name Relationship to Patient

_____

_____

_____

_____

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature: _____ Date_____