*Michelle K Calvosa, MD*

# RELEASE OF MEDICAL INFORMATION REQUEST

Patient medical records are CONFIDENTIAL. Protecting your privacy is very important to us, therefore, according to federal regulations; we may not discuss or release information to anyone but the patient unless you authorize us to do so. We want to make sure that you receive information that is necessary to assist us in providing quality care and service. Please complete the information below so that we may better serve you and your needs.

Patient Name: _____ Date of Birth: _____

I give this office permission to contact me by (initial all that apply):

_____ Telephone my home

_____ Telephone my work Phone # _____

_____ Leave messages on answering machine

_____ Other, explain: _____

If you would like us to discuss your information with anyone other that yourself, please write his/her name below and the relationship (i.e. spouse, children, friend, etc):

Signature of Patient or Personal Representative: _____

Print Name if not Patient:_____Relationship: _____

Date: _____