OAK RIDGE GASTROENTEROLOGY ASSOCIATES, P.C.

PHONE MESSAGE RELEASE FORM

Name: _____ Account No: _____

☐ I do **not** authorize O.R.G.A. to release health-related information pertaining to me to anyone other than myself.

☐ I authorize O.R.G.A. to release health-related information pertaining to me to the following people at my <u>home.</u> I have checked the information I am giving consent for O.R.G.A. to release:

- ❑ Appointments and referrals
- ❑ Test results (blood work, diagnostics)
- ❑ Medications

My **home** phone number is (_____)

Name	Relationship

☐ I authorize O.R.G.A. to release health-related information pertaining to me to the following people at my <u>work.</u> I have checked the information I am giving consent for O.R.G.A. to release:

- ❑ Appointments and referrals
- ❑ Test results (blood work, diagnostics)
- ❑ Medications

My **work** phone number is (_____)

Name	Relationship

This release will be in effect for one year from the date signed.

Patient's Signature _____ Date ____/____/_____