# AUTHORIZATION FOR RELEASE OF INFORMATION

There are times that it is necessary to contact a patient regarding scheduled appointments, lab results, radiology reports, or other questions relating to treatment. Without the signature of the patient, we cannot give personal medical information (unless the patient is a minor under the age of 16), to anyone ***including*** a spouse, parent, or child. The following are some circumstances in which you may allow us to provide your medical information to another family member and/or designated person. Please review the following, apply your ***initials*** next to the statement(s) approved by you, and sign the bottom line.

_____ I authorize the physicians and/or staff at Penn Medicine Westtown to call me and leave a DETAILED message on my home and/or cell answering machine about my health care.

_____ I authorize the physicians/and/or staff at Penn Medicine Westtown to call my place of employment to speak with me personally about my health care or leave a message to return their call.

_____ I authorize the physicians and/or staff at Penn Medicine Westtown to speak with the listed Individuals below about my health care, records, prescriptions, results, etc.

***Name:*** _____ ***Relationship:*** _____

***Name:*** _____ ***Relationship:*** _____

***Name:*** _____ ***Relationship:*** _____

## Email Address

*** _____ ***

| | |
|---|---|
| **Patient Printed Name**: | **Date of Birth**: |
| **Patient Signature**: *(Please sign in front of Westtown staff)* | |
| **Witness Signature**: | **Today's Date**: |

*By signing above, I understand that this authorization shall remain in place until revoked by the patient or their legal representative in writing. I understand that my refusal to sign this authorization form will not affect my ability to receive treatment.*