FAMILY FIRST
WOMEN & CHILDREN'S HEALTHCARE
MEDICAL AESTHETICS

Authorization to Disclose Personal Health Information

In order to ensure that results are communicated timely and to the appropriate party, we ask that you provide our office with the following information:

I authorize Family First's physicians and staff to discuss my personal health information, including NORMAL test results with:

☐ Patient only (please indicate which phone number(s) we may use to contact you)

☐	Home	May we leave a message?	☐	Yes	No ☐
☐	Work	May we leave a message?	☐	Yes	No ☐
☐	Cell	May we leave a message?	☐	Yes	No ☐

☐ Other (please complete information requested below)

Name:	Relationship:	
Home:	Work:	Cell:
Name:	Relationship:	
Home:	Work:	Cell:

☐ I would prefer to call the office directly to obtain my results.

I authorize Family First's physicians and staff to discuss my personal health information, including ABNORMAL test results with:

☐ Patient only (please indicate which phone number(s) we may use to contact you)

☐	Home	May we leave a message?	☐	Yes	No ☐
☐	Work	May we leave a message?	☐	Yes	No ☐
☐	Cell	May we leave a message?	☐	Yes	No ☐

☐ Other (please complete information requested below)

Name:	Relationship:	
Home:	Work:	Cell:

Name:	Relationship:	
Home:	Work:	Cell:

I authorize Family First's physicians and staff to provide prescriptions or medications intended for me to the following individua
I understand that anyone other than me must provide a photo ID before a prescription or medication will be released.

Name:	Relationship:

Name:	Relationship:

Patient Signature: Date:

Signature of Parent/Legal Guardian: Date: