

PL Physicians

Authorization to Release Patient Information

Date: _____

I, _____ hereby authorize Dr, _____
PL Physicians, and/or their representatives to release any and all information pertaining
to my health care, results, procedures, billing, and/or accounting information
to the following person(s) or agencies:

_____ Myself

_____ Insurance

_____ Spouse – Name: _____

_____ Parent – Name(s); _____

_____ Other – Specify: _____

_____ To No One

I further authorize the providers and their representative(s) to release results of my
medical exams in one or more of the following ways:

May call me (patient): _____ at home between _____ am/pm to _____ am/pm

_____ at work between _____ am/pm to _____ am/pm

May leave a message: _____ at home _____ at work

_____ on answering machine at home and/or _____ at work

I understand that this office will release any information to those persons who I have
determined may receive this information without separate consent. I also understand that
this relates to all medical and billing/account information. **THIS WILL BE
ACTIVELY ENFORCED**. If you wish to change the status of this form, you must
do so in writing.

Patient Signature

Date

Authorized Witness

Date