MOWERY CLINIC
AUTHORIZATION FOR USE OF
PROTECTED HEALTH INFORMATION

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Printed Name of Patient | Patient's Date of Birth | Patient's Social Security #

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Printed Name of Person Submitting Request (if other than Patient) | Relationship to Patient

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Mowery Clinic, L.L.C., its physicians and/or staff to share verbally or otherwise diagnostic reports, other medical information, and all relevant portions of medical record information about me or the above named patient for whom I possess parental custody or other legal authority to:

First and Last Name	Relationship to Patient	Phone Number	Yes No Allow Messages?
First and Last Name	Relationship to Patient	Phone Number	Yes No Allow Messages?
First and Last Name	Relationship to Patient	Phone Number	Yes No Allow Messages?
First and Last Name	Relationship to Patient	Phone Number	Yes No Allow Messages?
First and Last Name	Relationship to Patient	Phone Number	Yes No Allow Messages?

NOTE: No verbal or phone message(s) will be left with any individual other than yourself or those persons listed above.

ALTERNATE COMMUNICATIONS:
I hereby authorize Mowery Clinic, L.L.C., to contact me via the following methods of communication with regard to my Protected Health Information (PHI) or the PHI of the above named patient (this includes, but is not limited to, appointments, test results, etc.).

NOTE: Please indicate the preferred order of contact for each of the alternate communication items listed below (i.e. indicate "1" for FIRST preference, "2" for SECOND preference, "3" for THIRD preference, etc.).

Pref #				
Pref #	Home Phone Number	May messages be left at this number?	Yes	No
Pref #	Day Phone Number	May messages be left at this number?	Yes	No
Pref #	Cell Phone Number	May messages be left at this number?	Yes	No
Pref #	Alternate Phone Number	May messages be left at this number?	Yes	No
Pref #	Email Address	May messages be left at this email address?	Yes	No
Pref #	Other (please include description)	May messages be left at this point of contact?	Yes	No

I understand that this authorization will be in effect for the duration of treatment and follow up unless terminated by me in writing.

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Patient Signature or Patient Representative Signature | Date