

Patient Consent to Release Information

I, _____, give permission to Dr. Tolboe's and Dr. Hiatt's office to contact me by using any of the following indicated methods for giving test results, discussing medical information and/or confirming appointments.

Please mark all that apply:

_____ Phone call

_____ Answering Machine

_____ Cellular Phone

_____ Voice Mailbox

_____ E-mail

Family members - Please list all family members whom we may release information to.

Name(s):

Signed _____

Date _____