RELEASE OF PERSONAL MEDICAL INFORMATION TO PATIENT

I wish to be contacted in the following manner (check all that apply)

Home Telephone_____

☐ O.K. to leave message with detailed information

☐ Leave message with callback number only

Work Telephone _____

☐ O.K. to leave message with detailed information

☐ Leave message with callback number only

Written Communication:

☐ O.K. to mail to my home address

☐ O.K. to mail to my work/office

☐ O.K. to fax to this number_____

☐ O.K. to e-mail this address:_____

Information about me may be released to (check all that apply and give name(s)of chosen individuals)

☐ Spouse_____
☐ Child_____
☐ Brother_____
☐ Sister_____
☐ Father_____
☐ Mother_____

_____ Date____/____/_____
Patient Signature

_____
Print Name

DELTA MEDICAL CLINIC
11803 S. Freeway Ste 205, Burleson, TX 76028
Phone: (817) 293-8797

DELTA MEDICAL CLINIC
505 N. Ridgeway Dr., Ste. 101, Cleburne, TX 76033
Phone: (817) 517-6522