Health Care Status Authorization

Dr. Mark Matey, DPM

I, _____ (name of patient)

Herby give authorization to Dr. Matey and staff for the release of information concerning that status of my health care, including results of laboratory and radiology test and to discuss my plan of treatment with:

_____

Name of Authorized Individual

_____

Relationship to Patient

I understand that I may revoke this authorization at any time.

_____

Patient Signature

_____

Witness

_____

Date

Authorization for use of Voice Mails

I, _____ (name of patient)

Authorize Dr. Matey and staff to provide detailed information to me via my home and/or work answering machine or cell phone voice mail concerning appointment, referral, and test information. I understand that I may revoke this authorization at any time.

_____

Patient (Parent) Signature

_____

Date