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GOLDEN TRIANGLE NEUROCARE, L.L.P.

HIPAA dictates that our office must do everything possible to protect your medical information. For this reason please indicate below WHO of your family or friends we may leave messages with or talk to regarding appointments, prescriptions, test results, surgery dates and any other medical need we may have.

Please list the phone number below where you can most likely be reached during our business day.

DAY TIME PHONE: _ _ _-_ _ _- _ _ _ _ CELL/PAGER: _ _ _-_ _ _-_ _ _ _

____ It is OK to leave message at home ____ It is NOT OK to leave messages at home

I will allow medical information and test results including ABNORMAL RESULTS and appointment information released to the following people:

Name	Relationship	Phone

_____I DO NOT want medical information or test results released to anyone BUT my self.

This form will be valid until revoked by me in writing.

_____

Patient Name Date

_____

Patient Signature

_____

Signature of Guardian/Parent if under 17