Lakeshore Health Partners
A Holland Hospital Physician Office

Information Release

Patient Name: _____ DOB: _____

PLEASE NOTE: All of our patients are notified of upcoming appointments in our office via telephone by our automated reminder service.

AUTHORIZATION TO LEAVE MESSAGES

O **I DO** authorize the physicians and employees of Lakeshore Health Partners to **leave information** regarding appointment changes, laboratory results, x-rays, or other diagnostic tests at the following contact numbers/voicemail:

_____

_____

O **I DO NOT** authorize the physicians or employees of Lakeshore Health Partners to leave any information regarding appointments changes, laboratory results, x-rays, or other diagnostic tests on my answering machine/voicemail.

AUTHORIZATION FOR RELEASE OF INFORMATION

Confidentiality laws require us to obtain your written consent before we can discuss any of your information with your family member(s) or friend(s).

Please choose ONE of the following:

O I **DO NOT** authorize verbal information to be released to **any** individuals

O I **DO** authorize my information to be released to the following individuals:

Name	Relationship	Phone

Patient (Guardian) Signature:_____ Date:_____