## Permission to Leave Messages or to Disclose Health Information

The following individual(s) have my permission to receive limited healthcare information from McKinley Medical Clinic. Limited healthcare information would be to contact the clinic in regards to appointments and follow-up. Your healthcare information will not be discussed with anyone without your permission.

Please list their name(s) and relationship to you and phone number or indicate "NO ONE".

| Name | Relationship / Phone number |
|---|---|
| ______________________ | ______________________ |
| ______________________ | ______________________ |
| ______________________ | ______________________ |

Generally, the information would be left on your home phone number. If you would like the clinic to leave the information on a different phone number please list below.

Home phone: ______________________

Cell phone: ______________________

Work phone: ______________________

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Please check one:

______ It is permissible to leave a message on my answering machine to contact McKinley Medical Clinic.

______ It is NOT permissible to leave a message on my answering machine to contact McKinley Medical Clinic.

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The following individuals have my permission to receive my healthcare information regardless of content:

| Name | Relationship |
|---|---|
| ______________________ | ______________________ |
| ______________________ | ______________________ |

This will continue to be in effect unless / until you contact us to change your information.

Please sign and date:

Signature: ______________________ Date: ______________________