Office Release Consent

I give Dr. Curtis Clark M.D. , Dr. Charles A. Gerk, M.D. , and Stacey Rhodes PA-C and their office staff permission to leave test results or other medical information to the following:

Please check all that apply:

_____ Home answering machine Phone # _____

_____ Work Voicemail Phone# _____

_____ Spouse Name _____

_____ E-Mail E-mail Address_____

_____ Other Name & Phone _____

Print Patient's Name _____

Signature: _____

Date: _____

This consent will never expire, I will inform the office if there are any changes I would like to have made. _____
Please Initial