Family Health Care Center, LLC
19 Church Hill Road · Newtown, CT 06470
Tel: (203) 426-1818 · Fax: (203) 426-9253

AUTHORIZATION TO LEAVE MESSAGES

Due to the new confidentiality laws we cannot leave any messages for you anywhere unless you authorize us to do so.

Please complete the following:

I, ____________________________ with DOB ____________________
S.S. # _________________________ authorize any provider or member of the staff at *Family Health Care Center, LLC* to leave messages regarding mine or my minor children's ______________ *(DOB)* ________ test results, laboratory tests, cat scan, x-ray, MRI or any other diagnostic test. I authorize you to leave messages regarding confirmation of appointments and billing questions, even if in the message there is information regarding my visit in question.

You can leave messages on:

My cell phone # ________________________________

My home phone # ________________________________

My work phone # ________________________________

Other phone # ________________________________

AUTHORIZATION TO TALK TO SOMEONE ELSE REGARDING TREATMENT OR BILLING.

I authorize any provider or member of the staff at *Family Health Care Center, LLC* to give information regarding my visit, treatment, laboratory or diagnostic test results, billing matters and any other information concerning my treatment to: ________________________________

____
(Relationship)

DOB ______________________ S.S. # ___________________________

I can revoke this authorization in writing at any time.

SIGN ________________________________ *Date* __________________