



# Emmitsburg Osteopathic Primary Care Center

121-123 W. Main Street, Rear

P.O. Box 1219

Emmitsburg, MD 21727

## Permission to Release Protected Health Information- Including Diagnostic Information to a Third Party

Effective Date: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_  
*Please print*

Patient's Date of Birth: \_\_\_\_\_

Patient's Telephone #: \_\_\_\_\_

***I give Bonita J. Krempel-Portier, D.O., and her medical office staff my permission to release:***

Any test results and/or medical instructions to the following person(s)...

\_\_\_\_\_

*Name*

\_\_\_\_\_

*Relationship*

\_\_\_\_\_

*Name*

\_\_\_\_\_

*Relationship*

Only the following specified medical information to the following person(s)...

\_\_\_\_\_

\_\_\_\_\_

*Name*

\_\_\_\_\_

*Relationship*

\_\_\_\_\_

*Name*

\_\_\_\_\_

*Relationship*

I give authorization to leave protected health information on my home telephone answering machine or my voicemail.

This authorization expires: \_\_\_\_\_

*Please specify date or indicate "upon my written request"*

\_\_\_\_\_

*Signature of Patient/guardian*

\_\_\_\_\_

*Date*