Privacy Release Form

I, ____________________________, hereby give permission for the physicians and office staff at **Lowe & Freyaldenhoven, MDs** to discuss my <u>medical condition and care</u> with the following persons (i.e. family members, personal friends, employers, etc.):

Name	Relationship	Phone

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I, ______________________________, hereby give my permission for the office staff at **Lowe & Freyaldenhoven, MDs** to discuss my <u>account information</u> with the following person(s):

Name	Relationship	Phone

****

If the physicians or staff need to contact me at my home or work phone numbers, please:

_______Do not leave <u>any</u> messages indicating that you are a physician's office; please leave phone number only.

_______Do not leave any messages <u>other</u> than the name of the physician's office & phone number.

_______You have my permission to identify your office when calling my work/home phone numbers and to leave an abbreviated message.

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I understand that if I want to request copies of my medical records, that request will need to be made either in person or in writing, including my signature.

_______ I have been offered a copy of the current Notice of Privacy Practices.

Signed ____________________________________ Date: ___________________