



Flora Medical Clinic, PLLC

Consent to Call and Communicate

Authorization for phone /e-mail messages

- I authorize Flora Medical Clinic to leave detailed messages regarding my lab results and other healthcare information on following number or e-mail address.

Home phone- _____

☐ Yes

☐ No

Cell phone- _____

☐ Yes

☐ No

E-mail address- _____

☐ Yes

☐ No

Authorized Individual to receive PHI on your Behalf

- I give Flora Medical Clinic permission to release information regarding my healthcare, including, but not limited to, appointment information, test results, etc., whether in written, oral, and/or electronic format, to the individuals below. Please include name, relationship, DOB and contact information to help us verify their identity.

Name: _____ Relationship: _____ DOB: _____ Ph.# _____

I have read and understood the above information.

Signature of Patient or Personal Representative

Description of Personal Representative's Authority

Printed Name of Patient or Personal Representative

Date