Flora Medical Clinic, PLLC

Consent to Call and Communicate

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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

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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.#_____

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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

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