Day Kimball Medical Group, INC.
Permission to Share Information

Patient's Name: _____Date of Birth:_____

One of our goals is to protect your rights to privacy; therefore, unless we have your permission, information will not be given to anyone regarding you or your child's condition.

May we call you at work? ☐ YES ☐ NO

May we call you at home? ☐ YES ☐ NO

*If no to both questions, do you have an alternative number (i.e. cell phone)?_____

May we leave messages (including laboratory results or other diagnostic tests) on your answering machine? ☐ YES ☐ NO

May we speak with your spouse or significant other regarding your personal health information? ☐ YES ☐ NO

Is there another person we may release you or your child's personal health information to? We will only provide information to those listed below. ☐ YES ☐ NO

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

May we send you a fax? ☐ YES Fax#:_____ ☐ NO

_____

Patient/Guardian Signature Date