



ALISON T. SNIDER, MD
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AUTHORIZATION TO RELEASE INFORMATION

I, _____, give permission to Laurel Creek Family
Name of Patient
Medicine and its representatives to share my health or billing information with the
following people who are involved in my care:

<u>Name</u>	<u>Relationship</u>	<u>Contact Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I also give permission for test or appointment information to be left on my answering machine. I understand that LCFM will attempt to contact me by phone or mail with all lab or test results. As a reminder, our office policy states *“if you have not received a test result within two weeks of your appointment, please call our office.”* DO NOT ASSUME A TEST IS NORMAL IF YOU HAVE NOT HEARD FROM US.

Signature: _____ Date: _____

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