Physician Office
Medical Records Authorization

I,_____, the undersigned, hereby authorize Esse Health, its representatives, physicians and staff, to share any and all medical and financial information with the following individual(s):

1. Name:_____ Home:_____
Relationship to Patient:_____ Work:_____
_____ Cell:_____

2. Name:_____ Home:_____
Relationship to Patient:_____ Work:_____
_____ Cell:_____

3. Name:_____ Home:_____
Relationship to Patient:_____ Work:_____
_____ Cell:_____

Authorized by:

_____
Print Patient Name

_____ _____
Patient Signature Date

I understand that this authorization is voluntary and that I can refuse to sign this authorization. I do not have to sign this form to receive care.

I understand that I may revoke this authorization at any time by signing in the designated space below.

I hereby revoke this authorization.

_____ _____
Patient Signature Date

Physician Office
Message Authorization

I,_____, the undersigned, hereby authorize Esse Health, its representatives, physicians and staff, to leave message(s) related to my healthcare on a recorder at the following phone number(s):

Home:_____ Work:_____ext._____

Cell:_____

Authorized by:

_____
Print Patient Name

_____ _____
Patient Signature Date

I understand that this authorization is voluntary and that I can refuse to sign this authorization. I do not have to sign this form to receive care.

I understand that I may revoke this authorization at any time by signing in the designated space below.

I hereby revoke this authorization.

_____ _____
Patient Signature Date