Alliance Family Practice
4505 Fair Meadows Lane
Suite 101
Raleigh, NC 27607

Date _______________

I authorize Alliance Family Practice personnel to leave confidential healthcare information including test results at any of the following:

__________I authorize that any healthcare (including lab reports, test results, etc.) and/or billing related information may be left on my home answering machine.

__________I authorize that any healthcare (including lab reports, test results, etc.) and/or billing related information may be left on my work voice mail.

__________I authorize that any healthcare (including lab reports, test results, etc.) and/or billing related information may be left with:

Full name of person: ____

I do not authorize any healthcare or billing related information being release in any of the above fashions. Such information should only release to me personally.

I authorize the person listed below to pickup prescriptions, samples, forms and medical records.

Full name of person ____

Note: Photo ID will be required

Patient Name ___________________________________

Patient Signature ________________________________