KIRK HEALTH CLINIC, P.C.
1539 WEST ANDREW JOHNSON HIGHWAY
MORRISTOWN, TN 37814
423-585-5556

Authorization to Release Information

Date_____

Patient Name:_____Date of Birth:_____

I hereby authorize the following individual(s), other than myself, to receive information regarding my healthcare, diagnostic results, appointments, billing and/or collections:

Name:_____Date of birth:_____Relationship:_____

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Name:_____Date of birth:_____Relationship:_____

Name:_____Date of birth:_____Relationship:_____

Name:_____Date of birth:_____Relationship:_____

I hereby authorize Kirk & Kirk Health Clinic, P.C. to leave messages pertaining to my appointments, billing, and/or collections at the following numbers:

____ cell phone #_____

____ home phone #_____

____ work phone #_____

____ other # _____

Patient Signature:_____Date:_____

Parent or Guardian's Signature:_____Date:_____