Notice of Privacy Release Form

I, (print full name) _____ have received/ was offered a copy of the Notice of Privacy Release Form on (today's date) _____.

By signing this form I am giving consent for Tristan Medical to call my home, mobile phone or any other designated location and leave a message in reference to any items that may assist the practice in carrying out typical office functions. I am aware that these items may include the following: appointment reminders, insurance issues, laboratory results, x-ray results, and any other medical information that requires Tristan Medical to contact me.

By signing this form I am giving consent for Tristan Medical to mail my home or designated location any items that may assist the practice in carrying out typical office functions. I am aware that these items may include the following: appointment reminders, insurance issues, laboratory results, x-ray results, and any other medical information that requires Tristan Medical to contact me.

I give Tristan Medical consent to contact the following people to discuss my medical information with:

Name: _____Relationship: _____ Phone Number: _____

Name: _____Relationship: _____ Phone Number: _____

Patient's Signature: Today's Date:

_____ _____