



**BILLERICA MEDICAL & HEALTH CENTER**

221 Boston Road Suite 4, Billerica, MA 01862

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**PERMISSION TO RELEASE MEDICAL INFORMATION**

I give permission for Billerica Medical & Health Center to release my medical information to the following people: (Example-spouse)

<u>Name</u>	<u>Relationship To You</u>	<u>Phone Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give permission for Billerica Medical & Health Center to call me at home:  
(Check one) Yes \_\_\_\_\_ No \_\_\_\_\_ Phone \_\_\_\_\_

I give permission for Billerica Medical & Health Center to leave messages on my home answering machine:  
(Check one) Yes \_\_\_\_\_ No \_\_\_\_\_

I give permission for Billerica Medical & Health Center to call me at work:  
(Check one) Yes \_\_\_\_\_ No \_\_\_\_\_ Phone \_\_\_\_\_

I give permission for Billerica Medical & Health Center to leave messages on my work answering machine:  
(Check one) Yes \_\_\_\_\_ No \_\_\_\_\_ Phone \_\_\_\_\_

I give permission for Billerica Medical & Health Center to contact me by email:  
(Check one) Yes \_\_\_\_\_ No \_\_\_\_\_ Email \_\_\_\_\_

I give permission for Billerica Medical & Health Center to send messages about my medical condition by email:  
(Check one) Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date