Bradenton • Lakewood Ranch • Sarasota
URGENT CARE
WALK-IN CLINICS

Medical Information Release and Message Authorization

I give permission to Manatee Physician Alliance to release my medical information to the following people named below (this does not apply to other physicians: it does apply to family members, friends and others with whom you would allow such information to be shared).

Please **PRINT**

Name and relationship: _____

Name and relationship: _____

Name and relationship: _____

Name and relationship: _____

I authorize the providers and representatives of Manatee Physician Alliance to leave messages regarding my test results/appointments/financial information on my voicemail at numbers below if they do not reach me.

Please CHECK **all** that apply: ☐ HOME ☐ CELL ☐ WORK

I authorize the providers and representatives of Manatee Physician Alliance to leave messages regarding my test results/appointments/financial information with any of the above authorized people, if they do not reach me.

Please CHECK: ☐ YES ☐ NO

Signed:_____ Date of Birth:_____

Print Name:_____ Date Signed:_____

Manatee
Physician Alliance