



Backus Physician Services
12 Case Street, Suite 313
Norwich, CT 06360

Patient Name: _____
Date of Birth: _____

I authorize Backus Physician Services and employees to release medical information (i.e. test results, appointments and information about medication I have been prescribed) to: Please check all that apply:

Family Members: _____ Spouse
_____ Children
_____ Parent
_____ Other Family Members (please specify)
_____ Other (please specify)

Signed: _____ Date: _____

I do not want messages left with anyone other than myself. _____

I give permission for information to be left on my answering machine. Please check all that apply:

_____ Appointments at Hospital
_____ Appointments with other Physicians
_____ Test Results
_____ Information regarding prescriptions that I am taking or changes in prescriptions
_____ Reminders about upcoming appointments in this office.

Signed: _____ Date: _____

This release remains in effect until revoked by patient.