COMMUNICATION CONSENT

Ryan R. Gilroy, D.C.
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It is the office policy of Ryan R. Gilroy, D.C. not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence.
I authorize Ryan R. Gilroy, D.C. and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone____________________ ____Yes ____No

Answering Machine__________________ ____Yes ____No

Work Telephone____________________ ____Yes ____No

Voice Mail________________________ ____Yes ____No

Cell Phone and/or Voice Mail___________ ____Yes ____No

Pager____________________________ ____Yes ____No

Fax Medical records for referrals
to another entity____________________ ____Yes ____No

If you would like to have information released to someone other than yourself please complete the following:

Please list names of authorized people:

Spouse____________________________ ____Yes ____No

Parent____________________________ ____Yes ____No

Other names (Please list relationship) ____Yes ____No

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Patient/Guardian Signature:____

Date:________________