

WAVERLY PRIMARY CARE
600 New Waverly Place, Suite 203
Cary, NC 27518
919-859-5650

Date _____

I authorize Waverly Primary Care's personnel to leave confidential healthcare information including test results at any of the following:

_____ I authorize that any healthcare (including lab reports, test results, etc.) and/or billing related information may be left on my home answering machine.

_____ I authorize that any healthcare (including lab reports, test results, etc.) and/or billing related information may be left on my work voice mail.

_____ I authorize that any healthcare (including lab reports, test results, etc.) and/or billing related information may be left with:

Full name of person: _____

I do not authorize any healthcare or billing related information being release in any of the above fashions. Such information should only release to me personally.

I authorize the person listed below to pickup prescriptions, samples, forms and medical records.

Full name of person _____

Note: Photo ID will be required

Patient Name _____

Patient Signature _____