

OWEN DRIVE SURGICAL CLINIC OF FAYETTEVILLE, PLLC
F. ANDREW MORFESIS, MD, FACS
KELLY VAN FOSSEN, DO
DOMINIC LOUIS PAUL STORTO, D.O.
513 OWEN DRIVE
FAYETTEVILLE, NC 28304

INFORMATION RELEASE AUTHORIZATION FORM

DATE: _____

I authorize the staff of Owen Drive Surgical Clinic of Fayetteville, PLLC to the following:

1. Authorize Dr. Morfesis, Dr. Van Fossen or Dr. Storto to access and review my records as medically needed. Yes No
2. Leave messages on my answering machine at home Yes No
3. Leave messages at my work Yes No
4. Leave messages with my emergency contact person Yes No
5. Discuss my medical condition with NO ONE but me my spouse with the following persons:

Name: _____ Relationship _____

Name: _____ Relationship _____

6. I authorize the following person(s) to act on my behalf when calling about an appointment or for refills, or for any other medical necessity:

Name: _____ Relationship _____

Name: _____ Relationship _____

This authorization is valid until modified or revoked by myself at anytime by written request.

Patient's Name (Please Print) _____

Signature of Patient or Legal Guardian: _____