OWEN DRIVE SURGICAL CLINIC OF FAYETTEVILLE, PLLC
F. ANDREW MORFESIS, MD, FACS
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, 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:______________________________________

Revised 02/16