



**Physician Office  
Medical Records Authorization**

I, \_\_\_\_\_, the undersigned, hereby authorize Esse Health, its representatives, physicians and staff, to share any and all medical and financial information with the following individual(s):

1. Name: \_\_\_\_\_ Home: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Work: \_\_\_\_\_  
\_\_\_\_\_ Cell: \_\_\_\_\_

2. Name: \_\_\_\_\_ Home: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Work: \_\_\_\_\_  
\_\_\_\_\_ Cell: \_\_\_\_\_

3. Name: \_\_\_\_\_ Home: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Work: \_\_\_\_\_  
\_\_\_\_\_ Cell: \_\_\_\_\_

Authorized by:

\_\_\_\_\_  
*Print Patient Name*

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
Date

I understand that this authorization is voluntary and that I can refuse to sign this authorization. I do not have to sign this form to receive care.

**I understand that I may revoke this authorization at any time by signing in the designated space below.**

**I hereby revoke this authorization.**

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
Date



**Physician Office  
Message Authorization**

I, \_\_\_\_\_, the undersigned, hereby authorize Esse Health, its representatives, physicians and staff, to leave message(s) related to my healthcare on a recorder at the following phone number(s):

Home: \_\_\_\_\_ Work: \_\_\_\_\_ ext. \_\_\_\_\_

Cell: \_\_\_\_\_

Authorized by:

\_\_\_\_\_  
*Print Patient Name*

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
Date

I understand that this authorization is voluntary and that I can refuse to sign this authorization. I do not have to sign this form to receive care.

**I understand that I may revoke this authorization at any time by signing in the designated space below.**

**I hereby revoke this authorization.**

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
Date