WILLIAM S. BURKES, M.D.

LINDA C. SMITH, M.D.

85 IH-10 N., SUITE 202
BEAUMONT, TX 77707

HIPPA dictates that our office must do everything possible to protect your medical information.

For this reason please indicate below WHO of your family or friends we may leave messages with or talk to regarding appointments, prescriptions, test results, and any other medical need we may have.

Please list the phone numbers you can most likely be reached during our business day.

DAYTIME PHONE: _____ CELL: _____

Is it okay to leave messages at home? Yes_____ No_____

I will allow medical information and test results including ABNORMAL RESULTS and appointment information released to the following people:

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ I DO NOT want medical information or test results released to anyone BUT myself.

This form will be valid until revoked by me in writing.

PATIENT NAME_____DATE_____

_____

SIGNATURE(OR PARENT OR GUARDIAN IF PATIENT UNDER 18 OR IF PATIENT UNABLE)