

Matthew S. Lief, M.D., F.A.C.S., P.A.

I, _____ GIVE PERMISSION TO DR. LIEF OR HIS STAFF TO LEAVE ANY RESULTS OF MY TESTS OR EXAM WITH: (PLEASE CHECK ALL APPROPRIATE SPACES).

- _____ LEAVE MESSAGE ON ANSWERING MACHINE OR FAX AT HOME
- _____ LEAVE MESSAGE WITH SPOUSE, FAMILY MEMBER
- _____ LEAVE MESSAGE WITH _____ (NAME OF PERSON)
- _____ LEAVE MESSAGE ON ANSWERING MACHINE AT WORK
- _____ LEAVE MESSAGE WITH ONLY MYSELF BY PHONE OR FAX _____ (INITIALS)

I, _____ GIVE PERMISSION FOR MY MEDICAL RECORDS TO BE FAXED OR MAILED TO: (PLEASE CHECK ALL APPROPRIATE SPACES).

- _____ MY PRIMARY CARE PHYSICIAN
- _____ MY GYNECOLOGIST
- _____ ANY OTHER PHYSICIAN OR FACILITY THAT WILL BE OR IS INVOLVED IN MY CARE
- _____ DR. MATTHEW LIEF
- _____ MY INSURANCE CARRIER _____ (INITIALS)

I, _____ GIVE PERMISSION FOR DR. LIEF OR HIS STAFF TO DISCUSS ANY MEDICAL CONDITION WITH: (PLEASE CHECK ALL APPROPRIATE SPACES).

- _____ MY SPOUSE
- _____ MY CHILDREN
- _____ MY PARENTS
- _____ OTHERS, _____ (INITIALS)

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS NECESSARY FOR DR. LIEF TO RENDER MEDICAL SERVICES BY SIGNING LIFETIME SIGNATURE BELOW.

PRIOR TO SIGNING THIS DOCUMENT, I HAVE READ, REVIEWED, BEEN GIVEN THE OPPORTUNITY TO ASK QUESTION ABOUT, AND UNDERSTAND DR. LIEF'S CURRENTLY EFFECTIVE NOTICE OF PRIVACY PRACTICES, AND DO HEREBY AGREE TO ITS TERMS.

SIGNATURE

TODAY'S DATE

MATTHEW S. LIEF, M.D.
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