Darrel Pierce MD

RELEASE OF PATIENT INFORMATION CONSENT

In the event we are unable to reach you by phone and speak with directly to you, please check the

PREFFERED method for our office to communicate with you:

_____ Leave a message on my answering machine or voicemail.
_____ Send notification in writing to my home address.

If you would like to assign others the privilege of accessing medical information, please indicate below the type of information accessible for each person:

NAME	DOB	RELATIONSHIP TO PATIENT	Full Disclosure	Medical Report Only	Appointment information

I understand that I may revoke or amend my consent for any individual listed above by providing such notice in writing to Lone Star Surgery, PLLC.

_____
Signature of Patient or Responsible Party

_____
Relationship to Patient

_____
Date

Pierce MD, PLLC
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Sulphur Springs, TX 75482
Phone: 903 243-4867