Richard P. Day, M.D. **Elizabeth N. Dacus, M.D.**
Nancy B. Stroud, M.D. **Elizabeth MacNaughton, WHNP**
Molly Senokozlieff, M.D. **Penelope Bowman, CNM**

AUTHORIZATION

I, (patient) _____, give permission for the following people to receive any confidential information regarding myself from the office of Richard Day, M.D.; Nancy Stroud, M.D.; Molly Senokozlieff, M.D.; Elizabeth Dacus, M.D.; and Elizabeth MacNaughton, WHNP.

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ _____
Patient's Signature Date

_____ _____
Witness Date

Test results may be left on my answering machine/voice mail.

_____(Patient Signature)

Please do NOT leave test results on my answering machine/voice mail.

_____(Patient Signature)

I understand that I may revoke this authorization, in writing, at any time.