5413 Crenshaw Rd.
Suite 400
Pasadena, TX 77505
Ph# 713-943-2800
Fax# 713-943-2801

Authorization to leave a message

I give my permission for the staff of Orion Medical to leave message concerning lab work, diagnostic tests and/or any other medical information related to my condition with the following:

Patients name:_____ DOB_____

CHECK ALL THAT APPLY
○ 1st Phone Number:
○ 2nd Phone Number:
○ Family member (spouse, children, parents, and/or brother/sister) Phone Number:
○ I do not give permission to leave message with anyone other than myself (patient)

Patient signature_____Date:_____