**Poolesville Family Practice** **Amar Duggirala, DO, MPH***

*Certified, American Board of Family Medicine

# Message Permission Form

I give permission for the staff of Poolesville Family Practice to leave messages regarding my medical information with the following persons:

_____

_____

_____

_____ _____

Patient Name Date

**19710 Fisher Ave., Ste J, Poolesville MD 20837•(301) 972-7600•Fax (301) 972-8006**