NAME_____DATE OF BIRTH_____

Communication Authorization

We take your medical confidentiality very seriously. We will not and cannot release information

Without your authorization allows our staff members to speak only with individuals you designate in the event you are not available to receive phone calls or you have an adult individual that helps coordinate your medical care.

As part of the Privacy Policy we will not leave any health information with any other persons unless you specifically authorize below.

_____I do not authorize anyone to receive information regarding my medical care.

_____ I authorize my physician and staff of the clinic to speak with:

Name_____ Phone _____

Relationship _____ ( )Appointments ( )Account ( )lab/Test Results ( )Medical Care

Name_____ Phone _____

Relationship _____ ( )Appointments ( )Account ( )lab/Test Results ( )Medical Care

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are referred to this staff.

I agree that should I desire this authorization, I will give written notice.

Patient Signature _____Date _____