Patient Name: _____ Patient Identifier #: _____

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

I. WHO TO CONTACT

I hereby give permission to ***Medical and Surgical Clinic of Irving*** to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s) and/or close personal friend(s).

Name	Relationship
Name	Relationship
Name	Relationship

❒ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

II. HOW TO CONTACT

I wish to be contacted in the following manner:

Home Telephone	Work Telephone	Cell Phone
❒ Ok to leave message with detailed information. ❒ Leave message with call back number only.	❒ Ok to leave message with detailed information. ❒ Leave message with call back number only.	❒ Ok to leave message with detailed information. ❒ Leave message with call back number only.

❒ Written Communication

❒ Ok to mail to my home address

_____

_____

_____

❒ Ok to mail to my work / office address

_____

_____

_____

❒ Ok to fax to this number _____

The duration of this authorization is indefinite unless otherwise revoked in writing, I understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of any medical information.

_____ _____

Signature of Patient or Legal Representation Date