

Patient _____

Patient DOB _____



Patient Preference Regarding Communication of Health Information

Who to Contact

I hereby give permission to Pediatric & Adolescent Specialists of Rockwall to disclose and discuss any information related to my medical condition(s) to/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).

How to Contact (Please check all that apply)

_____ OK to leave a message on my HOME PHONE with detailed information.

_____ Leave a message on my home phone with a call-back number only.

_____ OK to leave a message on my WORK PHONE with detailed information.

_____ Leave a message on my work phone with a call-back number only.

_____ 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 a specific authorization prior to the disclosure of any medical information.

Signature of Patient/Parent/or Legal Representative

Date