
AUTHORIZATION OF INFORMATION DISCLOSURE

- ❖ *Please list the family members or persons, if any, whom we may inform about your general medical condition, diagnosis including treatment, healthcare operations and payment.*

- ❖ *Please list the telephone number where you can receive calls about your appointments, test results or other healthcare information.*

HOME TEL: _____ OTHER #'S: _____

****Cell phones are not a secure and private line****

- ❖ *Can confidential messages (appointment reminders and changes, etc.) be left on your telephone answering machine?*

YES _____ NO _____

- ❖ *Please list the family members or persons, if any, whom may pick up prescriptions, lab slips or other healthcare information.*

- ❖ *Please indicate if you want all correspondence sent in a sealed envelope marked "CONFIDENTIAL"*

YES _____ NO _____

PATIENT'S NAME: _____

SIGNATURE: _____

DATE: _____