Patient's Communication Instructions, Patient's Release and Acknowledgment

Patient Name (PRINT): ____

Date of Birth: ______________

Patient Address: ____

TELL US WHAT YOU WOULD LIKE TO AUTHORIZE OR LIMIT WITH THIS FORM (check all that apply):
____I would like to UPDATE or CHANGE my telephone and/or email contact information
____I would like to AUTHORIZE or CHANGE MY AUTHORIZATION for certain individuals to have access to and/or receive communication and disclosures concerning my healthcare
____I would like to LIMIT or REVOKE my authorization for individuals that have previously had access to and/or received communication and disclosures concerning my healthcare

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Which of the following communication means are appropriate/acceptable for our office to communicate with you? (Please check all that apply)

____Home phone number - leave message to return call – no particulars NUMBER: ___________________

____Home phone number - leave message with particulars NUMBER: ___________________

____Work phone number - leave message to return call – no particulars NUMBER: ___________________

____Work phone number - leave message with particulars NUMBER: ___________________

____Cell number - leave message to return call – no particulars NUMBER: ___________________

____Cell number - leave message with particulars NUMBER: ___________________

____Email_____________________ (Please do not assume that email will be used by your physician for communication. Please talk to your physician about the use of email as a means of communication.)

____Other (EXPLAIN AND PROVIDE DETAILS)____

____Other (EXPLAIN AND PROVIDE DETAILS)____

Who are you authorizing our office to discuss your health situation with? (Please list all names)

____Discuss with no one

____Spouse: circle AUTHORIZED or UNAUTHORIZED (Name: ___________________________________)

____Child: circle AUTHORIZED or UNAUTHORIZED (Name: ___________________________________)

____Sibling: circle AUTHORIZED or UNAUTHORIZED (Name: ___________________________________)

____Other: circle AUTHORIZED or UNAUTHORIZED (Name: ___________________________________)

____Other: circle AUTHORIZED or UNAUTHORIZED (Name___________________________________)

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name___________________________Relationship_______________Phone: _____________

This authorization will expire on: ____________(If no date is specified, it will expire upon your written amendment and instructions through your execution of a change to the information contained on this form via a completion of a new/replacement form).

By signing below, I acknowledge that I have received and reviewed a copy of Tallahassee Primary Care Associates' Notice of Privacy Policies.

______________________________________ ____________
Signature of Patient or Legal Guardian Date

If not the patient, explain relationship and legal authority: ____

Our primary care is you.