**Name of Patient: ______________________________**

**Confidential Communication:** Communication between our practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you.

Home: ______________________ Work: ______________________

Cell phone: ___________________ Other: ______________________

**Disclosure of Medical Information:** Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals including family member(s) may have knowledge of assisting in your care. Please list the individuals who we are authorized to discuss your care and to get a message to you to call our office.
(NOTE: We cannot discuss your care with others, including spouses or other family members living with you, unless they are listed below).

| Name of Person | Relationship to patient | Phone Number |
| --- | --- | --- |
| _______________________ | ________________ | _______________________ |
| _______________________ | ________________ | _______________________ |

Do you permit the authorized members to access your patient portal? Yes or No

**Emergency Contact**: If we are unsuccessful at reaching you or the names provided above at the phone numbers listed, please list any alternatives who we can contact in case of an emergency.

| Name of Person | Relationship to patient | Phone Number |
| --- | --- | --- |
| _______________________ | ________________ | _______________________ |
| _______________________ | ________________ | _______________________ |

**Signatures:**
I hereby authorize the use or disclosure of the personal health information as described above.

Relationship to Patient: ______________________________

Patient/Guardian Signature: ___________________________

Date: _____ / _____ / _______