

Lawrence Family Practice Center, P.A.

Communication Authorization/Permission to Disclose

Patient Name: _____ Date of Birth _____

Please communicate with me in the following manner (check all that apply):

(Please indicate your preference)

___ My home telephone number is: _____

___ OK to leave a message with detailed information.

___ OK to leave a message with callback number only.

___ My work telephone number is: _____

___ OK to leave a message with detailed information.

___ OK to leave a message with callback number only.

___ My cell telephone number is: _____

___ OK to leave a message with detailed information.

___ OK to leave a message with callback number only.

___ Written communication:

___ OK to mail to my home address

___ OK to mail to my work/office

___ OK to fax to the number provided: _____

___ OK to e-mail me at: _____

You may discuss my Protected Health Information (my health status, treatment, test results, other health information, insurance & payment arrangements) with the individuals listed below because they are involved with my health care or payment:

Name of Individual & Contact #:

Relationship to Patient:

Patient or Legal Guardian Signature

Date: