PERMISSION TO COMMUNICATE WITH FAMILY AND FRIENDS OR VOICEMAIL

You have the option of providing us with a list of family and friends with whom we may discuss your health information. You are **not required** to provide a list or to sign this form.

By signing this form I give permission to Family Docs Clinic Physicians or staff to discuss health information with the people listed below who assist with my care. If **I do not want certain information discussed, I have listed it below.**

I understand that sensitive information, examples HIV, sexually transmitted disease, pregnancy test results will not be shared unless I fill out the Authorization to disclose Protected Health Information form.

Right to revoke: If you decide you do not want Family Docs Clinic to share your health information any longer, sign the revocation at the end of this form and give this form to Family Docs Clinic.

Family Docs Clinic cannot promise that the person you permit us to share your health information with will not share your health information with someone else you may not want to have your health information. You can keep a copy of this authorization, and can contact the Family Docs Clinic privacy officer to get a copy if you do not have one.

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do not discuss information about _____

_____

Would you like to set up a password for friends and family to use in order to receive information over the phone during an inpatient hospital stay or for office contact? Y N The password is _____

Check the boxes that apply:

	I give Family Docs Clinic permission to leave normal Lab/Test result on my answering machine/Voicemail
	I do not give Family Docs Clinic permission to leave any Lab / Test result on my answering / voice mail.
	I will allow release of Information to the American Red Cross for communications with family members of the U.S military, such as notifying service members of illness or death, including such illnesses for emergency leave requests, The follow information may be provided: Physician name, diagnosis, Prognosis, current condition, Life Expectancy, and recommendation for leave.

If your answering machine / voice mail does not identify you by phone number or name only a message to return a call will be left.

Patient Name printed _____

_____

Patient/Patient Representative Signature Date Print Name