Patient Protected Health Authorization

Please list the family members or other person, if any, whom we may inform about your general medical and your diagnosis and how to reach them.

Please list the family members or significant other, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY and how to reach them.

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home address.

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Please list the telephone number, if any, where you want to receive calls about your appointments, lab, and lab results or other health care information if other than your home.

Phone number: (___) - ___ - ____

Can a confidential message (i.e. Appointment reminders, lab results, etc.) be left on your voice mail? ☐ Yes ☐ No

Can we text you on your cell phone? ☐ Yes ☐ No Cell phone #: (___) - ___ - ____

Can we email you ? ☐ Yes ☐ No Email Address : _____

Patient : last name : _____ first name : _____ middle name : _____

Guardians Name : _____

Signature: _____ Date: _____