ANDOVER FAMILY MEDICINE

Patient Communication Authorization

This authorization gives Andover Family Medicine and its authorized representative(s) permission to disclose certain protected health information to persons I have designated.

PATIENT NAME: _____ **BIRTH DATE:** _____

CONTACT PHONE NUMBERS: CELL ( ) _____

HOME ( ) _____

WORK ( ) _____

IF YOU ARE NOT AVAILABLE, MAY WE LEAVE A DETAILED VOICE MESSAGE?

□ YES, PLEASE LEAVE A VOICE MESSAGE

□ NO, DO NOT LEAVE A VOICE MESSAGE

IF WE ARE UNABLE TO REACH YOU, WHO MAY WE COMMUNICATE WITH?
(Please check all that apply)

□ COMMUNICATE WITH SELF ONLY

□ SPOUSE Name: _____ Phone: _____

□ ANY/ALL INFORMATION □ PLANS OF CARE
□ APPOINTMENT INFORMATION □ REFERRAL INFORMATION
□ BILLING INFORMATION □ TEST RESULTS
□ MEDICATION INFORMATION □ OTHER _____

□ CHILD Name: _____ Phone: _____

□ ANY/ALL INFORMATION □ PLANS OF CARE
□ APPOINTMENT INFORMATION □ REFERRAL INFORMATION
□ BILLING INFORMATION □ TEST RESULTS
□ MEDICATION INFORMATION □ OTHER _____

□ OTHER Name: _____ Phone: _____

Relationship to patient: _____

□ ANY/ALL INFORMATION □ PLANS OF CARE
□ APPOINTMENT INFORMATION □ REFERRAL INFORMATION
□ BILLING INFORMATION □ TEST RESULTS
□ MEDICATION INFORMATION □ OTHER _____

I understand this authorization will remain in effect until specifically withdrawn or changed by me or the authorized representative signing this form.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Printed name of legal representative Relationship to patient