PATIENT COMMUNICATION AUTHORIZATION

This information is for Health Ministries Clinic use for communication regarding your health care or billing information. We will keep this information in your medical record.

PATIENT LEGAL NAME: _____

BIRTH DATE (MM/DD/YYYY): _____/_____/_____

PLEASE LIST CONTACT PHONE NUMBERS:

(Home) (_____)-_____-_____
(Work) (_____)-_____-_____
(Cell) (_____)-_____-_____

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

- ❑ No, do not leave a voice message
- ❑ Yes, please leave a voice message

IF YOU ARE NOT AVAILABLE – WHO MAY WE COMMUNICATE WITH?

- ❑ Communicate with self only

Please check all that apply.

- ❑ SPOUSE (Name): _____ Phone: (_____)-_____-_____
  - ❑ Any information
  - ❑ Test results
  - ❑ Appointment information
  - ❑ Billing information
  - ❑ Other _____
- ❑ CHILD (Name): _____ Phone: (_____)-_____-_____
  - ❑ Any information
  - ❑ Test results
  - ❑ Appointment information
  - ❑ Billing information
  - ❑ Other _____
- ❑ (Name): _____ Phone: (_____)-_____-_____
  (Relationship to Patient) _____
  - ❑ Any information
  - ❑ Test results
  - ❑ Appointment information
  - ❑ Billing information
  - ❑ Other _____

_____/_____/_____ _____
Date Patient or Legal Patient Representative Signature

_____
Printed name of legal patient representative and relationship

<u>Please notify us immediately of any changes.</u>