Health Ministries Clinic
COMMUNITY HEALTH CENTER

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. Please notify us immediately of any changes.

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? PLEASE CHECK ALL THAT APPLY.

☐ **Communicate with self only**

☐ **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 ____

____ _______/_______/____________

Patient or Legal Patient Representative Signature Date

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Printed Name of Legal Patient Representative and Relationship