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 Name: ______________________________________________ DOB: ______/_____/_______

**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 ☐ Appointment Information

☐ Test Results ☐ Billing Information

☐ Other: ____________________________________________________

☐ Child (Name): ____________________________________ Phone: (_______) _______-__________

☐ Any Information ☐ Appointment Information

☐ Test Results ☐ Billing Information

☐ Other: ____________________________________________________

☐ Name: ____________________________________ Phone: (_______) _______-__________

Relationship to Patient: ____________________

☐ Test Results

☐ Appointment Information

☐ Any Information

☐ Billing Information

☐ Other: ____________________________________________________

**EMERGENCY CONTACT(S)**

Contact Name: ______________________________ Contact Number: (_______) ________-__________

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other: _______________________

Contact Name: ______________________________ Contact Number: (_______) ________-__________

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other: _______________________

______________________________________________________ ______/_____/_______

**Patient/Guardian Signature** **Date**

______________________________________________________

**Printed Name of Patient/ Guardian and Relationship**