CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to me by my health care provider or employee of PREMIER PRIMARY CARE.

Do we have your permission to call you at home or at the number you have given? R Yes R No

If yes, may we leave the following information on your answering machine or voice mail?

Appointment Information R Yes R No

Billing Information R Yes R No

Medical Information R Yes R No

May we call you at work? R Yes R No

If yes, may we leave the following information on your work answering machine or voice mail?

Appointment Information R Yes R No

Billing Information R Yes R No

Medical Information R Yes R No

I give my permission to share the following information with the person(s) named below:

Name _____ Relationship _____
Appointment: R Yes RNo Billing: R Yes RNo Medical: R Yes RNo

Name _____ Relationship _____
Appointment: R Yes RNo Billing: R Yes RNo Medical: R Yes RNo

Name _____ Relationship _____
Appointment: R Yes RNo Billing: R Yes RNo Medical: R Yes RNo

Name _____ Relationship _____
Appointment: R Yes RNo Billing: R Yes RNo Medical: R Yes RNo

Patient Signature _____ Date _____