Patient Instructions for Communication Preferences

I authorize my doctor or staff to **leave messages** including certain medical information:

☐ YES May leave messages on my answering machine or voice mail:

☐ at HOME ☐ at WORK ☐ on my MOBILE / CELL PHONE

☐ YES May share information with the following individuals:

☐ My spouse or significant other_____
☐ My son or daughter_____
☐ Any relative_____
☐ Other_____

This information may include information such as:

☐ Lab test and x-ray results
☐ Information regarding prescription refills
☐ Information regarding appointments
☐ Instructions regarding treatments or medications
☐ All information, no exceptions

☐ NO Do not leave messages on my answering machine or voice mail. I prefer that my doctor or staff speak to me personally regarding any medical information.

I understand that I may notify the doctor's office at any time of changes to this request, which would require a new form and authorization to be completed.

_____ _____

Signature Date

Patient Label