

## Communication Authorization Information

*Please PRINT Clearly:*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

We may need to communicate with you when you are not in our office. In order for us to maintain your privacy we ask that you please fill out the information below.

- Do NOT release medical information to anyone other than myself.
- I give permission to the staff of PPMC's Occupational Health-CarePlex facility to leave/send medical information pertaining to me, my dependant or my minor child at the numbers/locations listed below:

Method/Location	Yes	No	Phone number + extension
Home			
Answering Machine			
Work Phone			
Cell Phone			
Other _____			

In some cases, you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner, etc.) Also please list their date of birth so we can verify who we are speaking with over the phone if they call.

Name	Date of Birth (for ID purposes)	Relationship to you	Phone number + extension

Comments:

**I assume the responsibility to inform the practice of changes in my phone number(s) and all information listed on this Communication Authorization Form as outlined above.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_