Family Care Clinic
717 W. Lampasas St.
Ennis, TX 75119

# Patient Preference Regarding Communication of Health Information

Patient: ________________________ DOB: ______________________

## I. Who to Contact

I hereby give permission to the Family Care Clinic to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

☐ **I DO NOT** wish to give permission for family members, relatives, or close personal friends to have access to any information regarding my medical condition.

## II. How to Contact

I wish to be contacted in the following manner:

| **HOME** TELEPHONE ( ) - | **CELL** TELEPHONE ( ) - |
|---|---|
| [ ] OK to leave message with detailed information<br>[ ] Leave message with call-back number only | [ ] OK to leave message with detailed information<br>[ ] Leave message with call-back number only |
| WORK TELEPHONE ( ) - | |

[ ] Written Communication:
- [ ] OK to mail to my home address:__________________________________
- [ ] OK to mail to my work/office address: ___________________________
- [ ] OK to fax to this number: _____________________________________

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of any medical information.

______________________________ ______________________________
Signature of Patient or Legal Representative Date