Patient Name:____ Patient Identifier #:_________________________________

Patient Preference Regarding Communication of Health Information

I. Who to Contact

I hereby give permission to the staff of HTPN 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	Phone Number
________________________	____________________	____________________
Name	Relationship	Phone Number
________________________	____________________	____________________
Name	Relationship	Phone Number

❒ **I do not wish to disclose any information with anyone.**

II. How to Contact

I wish to be contacted in the following manner:

Home Telephone:	**Work** Telephone:
❒ OK to leave message with detailed information ❒ Leave message with call-back number only	❒ OK to leave message with detailed information ❒ Leave message with call-back number only
Cell Telephone:	
❒ OK to leave message with detailed information ❒ Leave message with call-back number only	

❒ 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 a specific authorization prior to the disclosure of any medical information.

_______________________________________ _______________________________________

Signature of Patient or Legal Representative Date