

Patient Name: _____ Patient ID# _____

Patient Preference Regarding Communication of Health Information

I. Who To Contact

I hereby give permission to Dr. Kurt Rathjen 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 additional family members, relatives or close personal friends to have access to any information regarding my medical conditions(s)

II. How To Contact

I wish to be contacted in the following manner:

Home Telephone:	Work Telephone
<input type="checkbox"/> OK to leave message with detailed information	<input type="checkbox"/> OK to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Leave message with call back number only

<input type="checkbox"/> Written Communication
<input type="checkbox"/> OK to mail to my home address: _____

<input type="checkbox"/> OK to mail to my work/office address: _____

<input type="checkbox"/> 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 for persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature of Patient or Legal Representative

Date