

# Patient Preference Regarding Communication of Health Information

## I. Who to Contact

I hereby give permission to Jefferson Cardiology Association 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 \_\_\_\_\_

\_\_\_\_\_ 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:	Cell Telephone:
<input type="checkbox"/> OK to leave message with detailed information	<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"/> 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 mail 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 \_\_\_/\_\_\_/\_\_\_\_