

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 ___/___/____