Gilbert Podiatry
Medical Information Communication Preferences

Patient:_____ DOB_____/_____/_____

As our patient we may need to communicate with you when you are not in the practice. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care.

PLEAE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

____ I give permission to leave appointment reminder/medical information pertaining to me, my dependent or child, at the numbers listed below:

Method	Yes	No	Phone Number
Home			
Answering Machine			
Work Phone			
Cell Phone			

Without specific permission, we will not release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner, etc.):

_____ Do not release medical information to anyone other than myself
_____ I give permission to release medical information pertaining to me to the individuals listed below:

Name	Relationship (i.e. spouse, daughter, son, partner, etc.)	Phone Number

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

_____ _____
Signature Date

_____
Please Print Name