PF 5000

AUTHORIZATION TO COMMUNICATE PATIENT'S MEDICAL INFORMATION

COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE

(Signed original to be placed in the central medical record and copy to patient)

PATIENT IDENTIFICATION

Name:__________________________

Date of birth:_____________________

S.S. #:__________________________

Medical Record/Account#:__________

Office Name:_______________________

Address:___________________________

City/State/Zip:______________________

Phone number:_____________________

Fax number:_______________________

Physician name:____________________

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME:	RELATIONSHIP TO PATIENT	TYPE OF INFORMATION			
		ALL	Scheduling/ Appointment	Medical	Billing/ Insurance

Specific instructions or limitations:____

____

Validation code: _______________________________ (Please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/Legal Representative:________________________ Date:________

Relationship to patient:____