

Patient Name: _____ DOB: _____

FAMILY AND FRIENDS CONTACT FORM

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form)

Name/
Relationship: _____ Phone: _____

Name/
Relationship: _____ Phone: _____

Name/
Relationship: _____ Phone: _____

From time to time, we will leave a message for you on an answering machine, voice mail, or with another individual in your absence. Is it OK for such message to include details (such as diagnosis and medication information) at these numbers?

Phone (home): _____ Message: Yes: _____ No: _____

Phone (work): _____ Message: Yes: _____ No: _____

Phone (cell): _____ Message: Yes: _____ No: _____

Patient Signature: _____ Date: _____