Patient Name: ______________________________ Patient Identifier # ____________________

Patient Preference Regarding Communication of Health Information

Who to Contact

I hereby give permission to ***Arthritis Centers of Texas*** to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s) and/or close personal friend(s):

Name	Relationship
______________________________	____________________
______________________________	____________________
______________________________	____________________

☐ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

How to Contact

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of communication, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

If method of communication is by phone, please check the appropriate:

☐ OK to leave a message with detailed information.

☐ Leave a message with call-back number only.

☐ Home Phone ☐ Work Phone

☐ Fax ☐ Cell Phone

☐ Letter ☐ Other

Please print phone number clearly: ______________________________

In-Clinic Communication Only

☐ I request that communication regarding my medical condition(s) to occur **only** when I am in the clinic. Please print and hand me information when I am in the clinic. Do not call, mail, or otherwise communicate with me regarding my medical condition(s).

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 my specific authorization prior to the disclosure of any medical information.

______________________________ ____________________

Signature of Patient or Legal Representative Date

______________________________ ____________________

Name of Legal Representative Relationship to Patient