



COMMUNICATION
USE AND DISCLOSURE AUTHORIZATION

Section A: Please complete the following information for all requests

- 1. Today's Date: _____
- 2. Patient Name: _____
- 3. Date of Birth: _____ 4. Patient #: _____
- 5. Address: _____

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

- 1. You may leave the following messages on my answering machines:
 - Referral Information
 - Prescription Refill Information
 - Test Results
 - Other: _____

- 2. You may discuss information regarding my treatment and care with the following family members and/or friends:

- 3. You may contact me regarding my treatment and care at the following numbers:

Signature of Patient or Guardian

Date

Signature of Staff Person and Title

Printed Name of Staff Person and Title