Patient Name:_____ Patient Identifier #:_____

Patient Preference Regarding Communication of Health Information

I. Who to Contact

I hereby give permission to ***Allergy Rheumatology Immunology Associated of North Texas (ARIANT)*** 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	Phone number
_____	_____	_____
Name	Relationship	Phone number
_____	_____	_____
Name	Relationship	Phone number

☐ 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).

II. How to Contact

I wish to be contacted in the following manner:

Home Telephone:	Work Telephone:	Cell Phone:
☐ OK to leave message with detailed information ☐ Leave message with call-back number only	☐ OK to leave message with detailed information ☐ Leave message with call-back number only	☐ OK to leave message with detailed information ☐ Leave message with call-back number only

☐ Written Communication

☐ OK to mail to my home address _____

_____

_____

☐ OK to mail to my work/office address _____

_____

_____

☐ OK to fax to this number _____

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

_____ _____

Signature of Patient or Legal Representative Date