AUTHORIZATION TO DISCLOSE INFORMATION

Patient's Full Name: _____

SS#: _____

Date of Birth: _____

INSTRUCTIONS FOR LEAVING MESSAGES
AND/OR DISCLOSING YOUR PERSONAL HEALTH INFORMATION

OK to communicate with spouse? ☐ YES ☐ NO
Spouses Name: _____

OK to leave information on answering machine? ☐ YES ☐ NO

OK to communicate with parent/children? ☐ YES ☐ NO
Name(s): _____

OK to communicate with caregiver? ☐ YES ☐ NO
Name: _____

OK to communicate with any other person(s) ☐ YES ☐ NO

Please list: _____

Communicate only with me ☐ YES ☐ NO

THIS DIRECTIVE WILL BE CONSIDERED IN EFFECT UNTIL REVISED IN WRITING

Signature: _____

Date: _____

Other Comments: _____

_____

_____