French Broad Pediatrics

DISCLOSURE OF MEDICAL INFORMATION

Patient Full Name (PRINT) ______________________________ DOB ________________

Disclosure of Medical Information: Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and be assisting in your care. Please list the individuals who we are authorized to discuss your care with. (NOTE: We can not discuss your care with others, including spouses or other family members living with you, unless they are listed below.)

Name of Person	Relationship to Patient
______________________	________________
______________________	________________

Confidential Communication: Communication between this practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you.

☐ Home: ____________________ ☐ Work: ______________________

☐ Cell phone: ____________________ ☐ Other: ______________________

If we are unsuccessful at reaching you at the above phone numbers, please list others who we can contact to get a message to you to call our office. *An automated appointment reminder system will call your home number listed in our data base.*

Name of Person	Phone Number	Relationship to Patient
________________	________________	________________
________________	________________	________________

Messages: A request for return calls may be left on the following answering machine or voice mail *(check all that apply)*

☐ At home ☐ At work ☐ On my cell phone ☐ I do not authorize

I authorize any medical information regarding myself to be left on the following answering machine or voice mail

(Check all that apply) ☐ At home ☐ At work ☐ On my cell phone ☐ I do not authorize

Signatures: I hereby authorize the use or disclosure of the personal health information as described above.

Patient/Personal Representative Signature: ______________________________ Date: __________

PRINT Name of Personal Representative: ______________________________

Relationship of Representative to Patient: ______________________________

French Broad Pediatrics
Representative: ______________________________ Date: __________

Note: This restriction applies only to care provided by French Broad Pediatrics identified in the upper left hand corner of this form. Other providers involved in your treatment may require you to complete a separate request for restriction.
The below signature is to be used if you would like to make the above information terminate on a certain date.

This agreement is terminated as of __________ Signature ______________________ *(Date)* ________