Patient Name: ______________________________

Patient Preferences Regarding Communication of Health Information

I. Who to Contact

I hereby give permission to Dr. J. Michael Fite, M.D. to disclose and discuss any information related to my medical condition to/with the following family member(s), other relative(s), close personal friend(s), and physician(s).

Name	Phone Number	Relationship
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

_____I do not wish to give permission for additional family members, relatives, close friends, or physicians to have access to any information regarding my medical conditions(s).

II. How to Contact

I wish to be contacted in the following manner:

Cell Phone:________________________
[ ] Ok to leave message with detailed information
[ ] Leave message with call back number only

Alternate Phone:____________________
[ ] Ok to leave message with detailed information
[ ] Leave message with call back number only

The duration of this authorization is indefinite unless otherwise 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 Date

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