

COMMUNICATION AUTHORIZATION FORM/ NEW PATIENT PAPERWORK

TRI-CITY NEUROLOGY LLC
ALTERNATIVE PEOPLE COMMUNICATION
AUTHORIZATION FORM

PATIENT NAME: _____

PATIENT PHONE NUMBER: _____

WHEN IT COMES TO YOUR MEDICAL TREATMENT, WE STRIVE TO COMMUNICATE WITH YOU IN AS TIMELY AND PROFESSIONAL MANNER AS POSSIBLE. THERE ARE CERTAIN OCCASIONS WHEN FAMILY MEMBERS, FRIENDS OR OTHERS MIGHT BE INVOLVED IN YOUR CARE AS A PATIENT AND YOU WILL WANT OUR OFFICE TO BE ABLE TO COMMUNICATE DIRECTLY WITH THEM. IN ORDER TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION, PLEASE SHARE WITH US THE NAMES OF ANY OF THE OTHER PEOPLE WITH WHOM WE CAN DISCUSS YOUR CARE AND SHARE YOUR PROTECTED HEALTH INFORMATION.

PLEASE LIST ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS ASPECTS RELATED TO YOUR CARE:

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

Are there any other numbers you would like to be contacted at? _____

Home Phone: _____ Work Phone: _____

Okay to leave message on machine? Okay to leave message?

Leave message to call us back?

Leave detailed message (re: tests results, appointment times, ect)

PATIENT SIGNATURE: _____ DATE: _____