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 YOU 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: ______________