PATIENT COMMUNICATION AUTHORIZATION

PATIENT LEGAL NAME: ____

BIRTH DATE (MM/DD/YYYY): _____/______/_____________

FOR OFFICE USE
Chart # __________________

Physician: ________________

PLEASE LIST CONTACT PHONE NUMBERS:

(Home) (______) - ________ - __________________

(Work) (______) - ________ - __________________

(Cell) (______) - ________ - __________________

IF YOU ARE NOT AVAILABLE MAY WE LEAVE A VOICE MESSAGE?

□ NO, DO NOT LEAVE A VOICE MESSAGE
□ YES, PLEASE LEAVE A VOICE MESSAGE

IF YOU ARE NOT AVAILABLE - WHO MAY WE COMMUNICATE WITH ?

□ COMMUNICATE WITH SELF ONLY

Please check all that apply.

□ SPOUSE (Name) ____________________________ Phone: (______) - _________ - _____________________

□ ANY INFORMATION
□ TEST RESULTS
□ APPOINTMENT INFORMATION
□ BILLING INFORMATION
□ OTHER ________________________________

□ CHILD (Name) ______________________________ Phone: (______) - _________ - _____________________

□ ANY INFORMATION
□ TEST RESULTS
□ APPOINTMENT INFORMATION
□ BILLING INFORMATION
□ OTHER ________________________________

□ (Name) ______________________________________ Phone: (______) - _________ - _____________________

(Relationship to Patient) ____

□ ANY INFORMATION
□ TEST RESULTS
□ APPOINTMENT INFORMATION
□ BILLING INFORMATION
□ OTHER ________________________________

____________________ ____
Date Patient or legal patient representative signature

____
Printed name of legal patient representative and relationship

This information is for West Wichita Family Physicians, West Wichita Minor Emergency Office and West Wichita Surgery Center use for communication regarding your health care or billing information. We will keep this information in your medical record.

Please notify us immediately of any changes.