AUTHORIZATION TO DISCLOSE INFORMATION

Patient's Full Name: _____

SSN: _____

Date of Birth: _____

INSTRUCTIONS FOR LEAVING MESSAGES AND/OR DISCLOSING YOUR PERSONAL HEALTH INFORMATION

OK to communicate with your spouse? YES / NO

Spouses name: _____

OK to leave information on answering machine? YES / NO

OK to communication with parent/children? YES / NO

Name(s): _____

OK to communicate with caregiver? YES / NO

Name: _____

OK to communicate with any other person(s) YES / NO

Please listt: _____

Communicate only with me? YES / NO

THIS DIRECTIVE WILL BE CONSIDERED IN EFFECT UNTIL REVISED IN WRITING

Signature: _____

Date: _____

Other comments:

_____

_____