Authorization to Leave Messages

Patient Last Name__________________________ First Name_____________________ Middle Initial______ Suffix______ (Jr/Sr/II etc.)

Address____________________________________ City____________________________ State_ ___________Zip_________________

Date of Birth ______/______/______ Social Security Number ___________________

Which method of communication is preferred? ☐ No contact ☐ Mail ☐ Phone ☐ Email

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

With whom may we share information about your health? Please list below.

Note: In order for Family Physicians of Jonesboro to disclose your Private Health Information, the representative listed must be able to provide (2) of the (3) identifiers below:

1. Last 4 digits patient's social security number **2. Patient's date of birth** **3. Patient's zip code**

Name	Relationship to You	Telephone Number	May Discuss Diagnosis/Treatment	May Discuss Billing Info
______________	______________	______________	☐ Yes ☐ No	☐ Yes ☐ No
______________	______________	______________	☐ Yes ☐ No	☐ Yes ☐ No
______________	______________	______________	☐ Yes ☐ No	☐ Yes ☐ No
______________	______________	______________	☐ Yes ☐ No	☐ Yes ☐ No

Do you have a legal document that states who will make decisions if you are unable? ☐ Yes ☐ No

If yes, Name____ Relationship to Patient_______________________

Check one: ☐ General Power of Attorney ☐ Healthcare Power of Attorney

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature:____ Date: _______________

If legal representative, explain the capacity: ____

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