ACADEMIC MEDICAL ASSOCIATES

Patient's Name (First, Middle, Last): _____

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

I hereby give my permission to Academic Medical Associates to disclose and discuss information related to my medical condition(s) to/with the following persons:

Name: _____ Relationship: _____ Ph#:_____

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

____ I do not wish to give consent for any person to have access to any information regarding my medical condition(s).

Emergency Contact: _____ Relationship: _____ Ph#: _____

This authorization shall remain in effect unless otherwise revoked in writing, I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any records.

Signature of Patient or Legal Representative: _____

Printed Name and Relationship: _____ Today's Date: _____