Disclosure Agreement Form

In order to provide the best care possible, we may contact the patient with information regarding appointments, test results, and treatment plans. Please complete the following so that we can ensure that all communication regarding your protected health information remains confidential.

Methods to contact me:

E-Mail:_____

IMPORTANT TO PROVIDE TO BE USED FOR PATIENT PORTAL ACCESS AND APPOINTMENT REMINDERS

Phone: (_____) _____ ☐ Home ☐ Work ☐ Cell ☐ Cell Spouse ☐ Cell Mom ☐ Cell Dad
☐ Cell Other_____

Phone: (_____) _____ ☐ Home ☐ Work ☐ Cell ☐ Cell Spouse ☐ Cell Mom ☐ Cell Dad
☐ Cell Other_____

Phone: (_____) _____ ☐ Home ☐ Work ☐ Cell ☐ Cell Spouse ☐ Cell Mom ☐ Cell Dad
☐ Cell Other_____

May we leave messages on voicemail/answering machine? ____Yes ____ No

May we leave message with any other person? ____Yes ____ No

If yes, please specify who is authorized to accept information regarding your treatment:

_____
(Name) (Relationship to patient)

_____
(Name) (Relationship to patient)

_____
(Name) (Relationship to patient)

Mail: ☐ Same as address provided at registration

☐ Other: _____

This request may be changed or revoked by filing a new request or revoking this one in writing. Please be advised by signing this form you are authorizing us to share information with any of the above individuals and by the methods listed above.

Name: _____

Signed: _____ Date:_____/_____/_____

If you are not the patient, please specify your relationship to the patient:_____