Winter Park Primary Care
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COMMUNICATION USE AND DISCLOSURE AUTHORIZATION

Patient's Name: _____ Date of Birth: _____

I hereby request the following regarding the use of my personal health information:

1. **You may contact me via the following methods (please check ALL that apply):**

_____Preferred Phone Number _____
_____E-mail Address* _____
_____Ok to leave voicemail? _____ (yes/no)
_____Ok to text?* _____ (yes/no)

(*Please note that e-mailing and texting are unsecured methods of communication.)

2. **You _____MAY or you _____MAY NOT leave detailed messages for me regarding appointments, prescriptions, test results, referral information, billing information or other information pertaining to my treatment and care.**

3. **You may discuss information regarding my treatment and care with the following family/friends:**

_____	_____	_____
Full Legal Name	Relationship	Phone Number
_____	_____	_____
Full Legal Name	Relationship	Phone Number
_____	_____	_____
Full Legal Name	Relationship	Phone Number

_____ _____
Signature of Patient or Guardian **Date**

_____ _____
Printed Name of Witness/Staff **Signature of Witness/Staff**