



Patient Preference Regarding Communication of Health Information

**I. How to Contact**

I wish to be contacted in the following manner:

OK to leave message with detailed information at the following phone numbers:

- Home \_\_\_\_\_
- Cell \_\_\_\_\_
- Work \_\_\_\_\_

I prefer to receive confirmation of my appointment via

- Email \_\_\_\_\_
- Phone \_\_\_\_\_

**II. Who to Contact**

I hereby give permission to Allergy & Asthma Center of Texas to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

\_\_\_\_\_ I do not wish to disclose any information with anyone other than my insurance company as provided in Allergy & Asthma Center of Texas' Privacy Policy or as required by law.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Responsible Party)