JOHN R. GILMORE, M.D.

Patient Preference Regarding Communication of Health Information

Patient Name: _____ Patient Identifier #: _____

Who to Contact

I hereby grant permission to **Dr. John R. Gilmore, M.D.** 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

How to Contact- We do not respond by E-Mail. This is not HIPPA compliant

I wish to be contacted in the following manner:

Telephone:

Home/Work/Cell Telephone: ____ OK to leave a message with detailed information
(Please check) ____ OK to leave message with call back number

Written Communication:

____ OK to mail to my home address _____

____ OK to mail to my work/office address _____

____ OK to Fax to this number _____

The duration of the 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.

_____ _____
Signature of Patient or Legal Representative Date

_____
Witness Signature

_____

_____ **I DO NOT WISH TO GIVE PERMISSION FOR FAMILY MEMBERS, RELATIVES OR CLOSE PERSONAL FRIENDS TO HAVE ACCESS TO ANY INFORMATION REGARDING MY MEDICAL CONDITION.**

_____ _____
Signature of Patient or Legal Representative Date

_____
Witness Signature