SIGNATURE HEALTHCARE

Patient Name (Please Print):______________________________DOB:_______________

E-Mail Address:____________________________________Date:_______________

Home Phone:_______________Cell Phone:________________Work Phone:__________

Authorization of Confidential Communication

Signature Health is committed to safeguarding your protected health information. To communicate verbally with another individual of your choosing, or to receive a telephone message regarding an appointment reminder, test results, care planning, prescription, follow-up appointments, or other important messages from your providers we are asking for your written permission. Please mark the appropriate boxes below:

	Appointment Reminders		**Test Results, Care Planning or Prescription**		**Financial information**	
	Which is the best number to use? (Check one below)	Can we leave a voicemail on this number?	Which is the best number to use? (Check one below)	Can we leave a voicemail on this number?	Which is the best number to use? (Check one below)	Can we leave a voicemail on this number?
Cell	☐	☐	☐	☐	☐	☐
Home	☐	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐	☐

I give my consent to representatives of Signature Healthcare to discuss my care with the following individuals (please print):

1. Name:__________________________________Relationship: ______________________

   Phone #:________________________________Appointments: ☐ Clinical: ☐ Financial: ☐

2. Name:__________________________________Relationship: ______________________

   Phone #:________________________________Appointments: ☐ Clinical: ☐ Financial: ☐

3. Name:__________________________________Relationship: ______________________

   Phone #:________________________________Appointments: ☐ Clinical: ☐ Financial: ☐

For Emancipated Minors Under 18 Only
I want my account to be separate from my family: □ Yes □ No

I would like my medical bills to be sent to the address below. (Only for patients over 18 years of age)
Address to send bills, if different than residence:

Address: ____

City: ___________________________State: _________________Zip: _____________

I have read and understand this form and any questions have been answered in a language I understand. I agree with the information in this form and understand that this authorization will be in effect until I give written notice to change or withdraw my authorization.

Patient or Legal Guardian Signature: ___________________________________Date:__________