Persons who are involved in your care (family, friends, etc.) may inquire about your treatment, lab tests, prescriptions, etc. Please let us know what persons we may share information with. (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practices we may share information with others who are not specifically listed on this form.)

Please list all persons with whom we may share your information (If someone is not listed on this form, they will be told to contact you for treatment information) You are responsible for notifying our office when someone needs to be removed from this list:

_____

_____

_____

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail or with another individual in your absence. **Is it okay for us to leave a message for you at any of the below numbers?**
_____Yes _____No

What is the best phone number for us to contact you?

Home Phone Number:_____

Work Number:_____

Cell Phone Number:_____

Other:_____

Email Address:_____

PLEASE PROVIDE US WITH YOUR PHARMACY NAME AND NUMBER:

_____

Pharmacy Name Location Phone Number

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Print Name of Patient or Legal Representative Relationship if other than patient