ALLOWANCE FOR CONFIDENTIAL COMMUNICATIONS TO A THIRD PARTY

Name of Patient: _____ Date of Birth: _____
(Please print)

I grant permission for UAH Faculty and Staff Clinic to give information with regard to my medical care to the following person(s) or entity(ies). I understand that I may withdraw, in writing, one or all of these requests at any time.

Name of person given permission to receive medical information.	Relationship to patient (friend, spouse, other family member or physician)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I grant permission for UAH Faculty and Staff Clinic to leave messages as designated below:

	APPOINTMENT/REMINDER/CHANGES		TEST RESULTS	
HOME	YES	NO	YES	NO
WORK	YES	NO	YES	NO
CELLULAR PHONE	YES	NO	YES	NO

_____
Patient Signature

_____
Date

For Practice Use Only:

Practice: ☐ Accepts ☐ Denies

Privacy Officer Signature: _____

Date: _____

LCO/srw June 2007