ALLOWANCE FOR CONFIDENTIAL COMMUNICATIONS TO A THIRD PARTY

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

I grant permission for UAH Health Services 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 Health Services 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

**Signature:_____ Date:_____

Privacy Practices Acknowledgement

I have received and had the opportunity to review the Notice of Privacy Practices

**Signature _____ Date:_____

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