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 Notice:

I acknowledge that I have been given the opportunity to review the UAH Health Services Privacy Notice and Patient Rights and Responsibilities Statement which is posted at the front desk and online at uah.edu/shc and uah.edu/clinic, that I am entitled to have my own personal copy of the Privacy Notice, and that the clinic has made available a copy of this document for me to have.

**Signature _____ Date:_____

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