

ARIZONA ENDOCRINOLOGY CENTER
PATIENT COMMUNICATION SHEET

Patient Name: _____

The following instructions pertain to the above named patient:

(Please **circle** your responses below)

OK to call cell	Y	N	OK to leave message	Y	N
OK to call home	Y	N	OK to leave message	Y	N
OK to call work	Y	N	OK to leave message	Y	N

I give permission to disclose my health information to the individuals below:

_____ () Messages only or () All information
PRINT NAME Relation: () Spouse () POA () other: _____

_____ () Messages only or () All information
PRINT NAME Relation: () Spouse () POA () other: _____

_____ () Messages only or () All information
PRINT NAME Relation: () Spouse () POA () other: _____

_____ () Messages only or () All information
PRINT NAME Relation: () Spouse () POA () other: _____

Patient Signature: _____ **Date:** _____

Please Note: If your spouse is not listed above, information will not be disclosed to him/her.