Permission to Communicate

Client/Patient Name: _____

Date of Birth: _____

I authorize _____ to share my protected health information with family members or other health-care providers as designated by me below.

This permission is NOT an authorization to release medical records or a consent to treatment.

This permission also authorizes _____ to communicate with the authorized persons listed below by phone (including voice messages), in person, or by other means acceptable to _____.

Name: _____
Phone Number: _____
Relationship to Client/Patient: _____

Name: _____
Phone Number: _____
Relationship to Client/Patient: _____

Name: _____
Phone Number: _____
Relationship to Client/Patient: _____

I understand I am under no obligation to provide _____ with this Permission to Communicate and that _____ will not condition treatment, payment, or enrollment/eligibility for benefits on my decision to provide or not provide this form.

I understand I may revoke this Permission at any time, for any reason, if I so choose. I can revoke this Permission either by completing a new Permission to Communicate form and indicating my revocation on the form or by notifying _____ in writing of my revocation.

Communications should be sent to: _____.

NOT EFFECTIVE UNLESS SIGNED AND DATED

Signature: _____ Date: _____