Advanced Neuropathy Clinic

469-814-9787

Patient Name: _____ Date of Birth: _____

Patient Preference Regarding Communication of Health Information

I. Who to Contact

I hereby give permission to Advanced Neuropathy to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name	Relationship

☐ I do NOT wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

II. How to Contact

I wish to be contacted in the following manner:

Home/Cell Phone:

☐ OK to leave message with ***detailed*** information.
☐ Leave message with call-back number only

Work Phone:

☐ OK to leave message with *detailed* information.
☐ Leave message with call-back number only

☐ OK to **FAX** written information to this fax number: _____

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Patient Signature: _____ Date: _____