Patient Name:_____ Date of Birth:_____

AUTHORIZATION TO COMMUNICATE INFORMATION TO PATIENT

The undersigned authorizes Esse Health, its physicians, staff and representatives to communicate with me by leaving messages related to my healthcare at the following numbers:

Home:_____ Cell: _____ Work: _____

AUTHORIZATION TO COMMUNICATE INFORMATION TO OTHERS

The undersigned authorizes Esse Health, its physicians, staff and representatives to communicate information about my health with the following:

1. Name: _____ Home #:_____
   Relationship to Patient: _____ Cell #: _____
   Work #: _____
   May Discuss Diagnosis/Treatment: Yes _____ No_____
   May Discuss Billing Info: Yes _____ No _____

2. Name: _____ Home #: _____
   Relationship to Patient: _____ Cell #: _____
   Work #: _____
   May Discuss Diagnosis/Treatment: Yes ____ No _____
   May Discuss Billing Info: Yes _____ No _____

I understand that these authorizations are voluntary and that I can refuse to sign the authorization. I understand I may revoke this authorization at any time. I understand I do not have to sign this form to receive care. I understand it is my responsibility to update this list in order to keep accurate who can obtain information about my health.

_____ Date:_____
Patient/Legal Representative

SIGN BELOW ONLY IF YOU WISH TO REVOKE YOUR AUTHORIZATION

I hereby revoke this authorization.

_____ Date: _____
Patient/Legal Representative