

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 \_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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**