ARIZONA ENDOCRINOLOGY CENTER
PATIENT COMMUNICATION SHEET

Patient Name: _____Date: _____

The following instructions pertain to the above named patient:

(Please <u>circle</u> 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

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