West Wichita Family Physicians, P.A.

PATIENT COMMUNICATION AUTHORIZATION

Patient's Legal Name_____ Date of Birth_____

Preferred Phone Number_____

May we leave a detailed voice message at the number listed above? Y / N

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below.

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

_____ _____

Patient Signature/ or Patient's Legal Representative Date

_____

Printed name of patient's legal representative and relationship

This information is for West Wichita Family Physicians, West Wichita Minor Care, and West Wichita Surgery Center use for communication regarding your health care or billing information. We will keep this information in your medical record.

Please notify us immediately of any changes.