

**COMMUNICATION  
USE AND DISCLOSURE AUTHORIZATION**

**Section A: Please complete the following information for all requests**

- 1. Today's date: \_\_\_\_\_
- 2. Patient name: \_\_\_\_\_
- 3. Date of Birth: \_\_\_\_\_ 4. Patient #: \_\_\_\_\_
- 4. Address: \_\_\_\_\_

**I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:**

- 1. You may leave the following messages on answering machines
  - Referral Information
  - Prescription refill information
  - Test results
  - Other: \_\_\_\_\_
  
- 2. You may discuss information regarding my treatment and care with the following family members and/or friends:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
- 3. You may contact me regarding my treatment and care at the following numbers:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Person and Title

\_\_\_\_\_  
Printed Name of Staff Person and Title