

# ALABAMA FAMILY DENTISTRY, LLC

## Alternative People Communication Authorization Form

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_

When it comes to your medical treatment, we strive to communicate with you in a timely and professional manner as possible. There are certain occasions when family members, friends, or others might be involved in your care as a patient and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other people with whom we can discuss your care and share your protected health information.

Please list below any other people with whom you authorize our office to discuss aspects related to your care.

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_ Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_ Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_ Phone \_\_\_\_\_

**Do we have your permission to leave messages on voice mail or answering machines?**

**YES** \_\_\_\_\_

**NO** \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_