

PATIENT AUTHORIZATIONS

Patient Name: _____ DOB: _____

- I hereby authorize Dr. Simpson (from *Doc At Your Door, PLC*) full access to any and all of my medical records anywhere, and in any format, they may exist.
- I hereby authorize Dr. Simpson (from *Doc At Your Door, PLC*), full rights to communicate with any caregivers involved in my care, in all medical care settings (including but not limited to hospitals, rehab centers, nursing homes, assisted living facilities, outpatient centers, physician offices, home health, hospice, therapy centers, labs, pharmacies, etc.)
- Dr. Simpson may communicate with me by any of the following: (check all that apply)
 Home phone Cell phone Cell text E-Mail Patient Portal Postal Mail
- My preferred method of communication is: (check one or two)
 Home phone Cell phone Cell text E-Mail Patient Portal Postal Mail
- Dr. Simpson may leave detailed electronic messages for me, regarding my medical care (such as appointments, lab results, X-ray results, etc.)
 Yes No
- Dr. Simpson may share details of my medical information with:
 No one As follows:

Name	Relationship	Phone or E-mail
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Name	Relationship	Phone or E-mail
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I understand that the most secure method of communication is by phone or patient portal; I understand that opting to use texting, email, and postal mail is less secure, and I agree to not hold this practice or its staff responsible for any resulting breaches in confidential information. I understand that I may revoke any or all of this authorization at any time.

Patient Signature (or that of legal representative)	Date
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Legal Representative Name (please print)	Relationship
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