DOC AT YOUR DOOR
Physician House Calls and More

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
_____	_____	_____
Name	Relationship	Phone or E-mail

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**
_____	_____
Legal Representative Name (please print)	Relationship