Daisy Family Health, LLC
4150 W. Peoria Ave, Suite 121, Phoenix, AZ 85029
Phone: (602) 314.6960 Fax: (602) 429.8471
www.daisyfamilyhealth.com
patient@daisyfamilyhealth.com

_____ _____
Patient Name (printed) Date of Birth

ALTERNATIVE COMMUNICATION RELEASE FORM

I authorize MyDPCdoc Family Medicine, in regards to my protected health information:

____To call me at work
____To call me at home
____To call my cell phone
____To speak with anyone listed on the Right To Share Information list
____To only speak with me
____To fax information to me at this secured number_____
____To send me email at the following address _____
(Alternative address)
_____

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

Daisy Family Health, LLC reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy.

In order to have your PHI shared in other circumstances with members of your family or friends please list those individuals that we are authorized to release information.

_____ _____
Signature of Patient Date

_____ _____
Witness Date