107 N St Rd 135, Suite 103
Greenwood, IN 46278
(317)550-4510

Patient Communication Instructions

Patient Name (Printed): ______________________________

Date of Birth: ______________

I authorize Academy Primary Care staff to leave messages including certain medical information:

☐ NO — Do not leave messages on my answering machine or voicemail. I prefer that my doctor or staff speak to me personally regarding any medical information.

☐ YES — May Leave messages on my answering machine or voicemail:

☐ At Home ☐ At Work ☐ On my mobile/cell phone

☐ YES — May share information with the following:

Spouse or significant other: ______________________ (*Name*) ____________ (*Phone*)

My son or daughter: ______________________ (*Name*) ____________ (*Phone*)

Relative: ______________________ (*Name*) ____________ (*Phone*)

Other: ______________________ (*Name*) ____________ (*Phone*)

This shared information may include the following:

- ☐ Lab test and x-ray results
- ☐ Instructions for treatment or medications
- ☐ Information regarding refills
- ☐ All information, no exceptions
- ☐ Information regarding appointments
- ☐ Billing Information

I understand that I may notify the doctor's office at any time of changes to this request, which would require a new form and authorization to be completed

______________________ ______________

Patient Signature Date
(Authorized Representative)