AAA Medical Group

# Medical Information Communication Preferences

Patient_____ MR#_____ DOB____/____/____

As our patient, we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential medical information, such as lab test results, to you and/or others involved in your care. Please note that "appointment reminder telephone calls" may be left at the contact number(s) you list below. Please list your email address to receive on-line healthcare information provided by AAA MEDICAL GROUP - New Jersey.

**PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:**

❑ I give permission to **leave medical information** pertaining to **me, my dependent, or child**, at the numbers listed below:

| Method | Yes | No | Area Code, Phone #, Ext, E-Mail |
|---|---|---|---|
| Home Telephone | | | |
| Voicemail/Answering Machine | | | |
| Work Phone | | | |
| Cell Phone | | | |
| E-Mail for our Patient Portal secure email registration | | | |

Without specific permission, we will not release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner, etc.):

❑ Do **not release medical information** to anyone other than myself.
❑ I give **permission to release medical information** pertaining to me to the individuals listed below.

| Name | Relationship (i.e., spouse, parent, son, daughter, etc.) | Area Code, Phone # - Extension |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| **Comments** |
|---|
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I assume the responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____(Please Print Signer's Name)