

# Communication of Health Information

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**IF THIS PAGE IS NOT FILLED OUT, YOU WILL NEED TO MAKE AN APPOINTMENT TO RETURN TO HAVE MEDICAL INFORMATION DISCUSSED WITH DR. SKILES. NO MEDICAL CONDITION(S) WILL BE DISCUSSED WITH YOU UNLESS IT IS IN PERSON.**

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\_\_\_\_\_ I hearby give permission to the office, within the office, of Roger G. Skiles, M.D. to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or any close personal friend(s).

\_\_\_\_\_

Name

\_\_\_\_\_

Relationship

\_\_\_\_\_

Name

\_\_\_\_\_

Relationship

\_\_\_\_\_

Name

\_\_\_\_\_

Relationship

**-OR-**

\_\_\_\_\_ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

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**I wish to be contacted in the following manner:**

- By Phone:
  - Home: \_\_\_\_\_
  - Cell : \_\_\_\_\_
  - Work: \_\_\_\_\_
  - Options:
      - It is alright to leave a message with detailed information on answering machine or voicemail
      - Leave message with call-back number only.
- By Written Communication: (Information will be mailed to the following locations)
  - Email: \_\_\_\_\_
  - FAX: \_\_\_\_\_
  - Home Address \_\_\_\_\_ (As written on the *Patient Profile Form*)

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Print Name of Patient/Guardian

Date

Patient/Guardian Signature