Patient Name: ________________________

Date of Birth: ________________________

Wattles Park Family Practice

PATIENT COMMUNICATION CONSENT FORM

I agree to allow Wattles Park Family Practice to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize Wattles Park Family Practice to leave messages for me when I am unavailable. By checking the box and or listing a number on the line provided you are consenting to have messages left for you.

Method	**Number/Address**
__ Home Phone	(___) ____________________
__ Cell Phone	(___) ____________________
__ Work Phone	(___) ____________________
__ Alternate Phone	(___) ____________________
__ Patient Portal	

I authorize Wattles Park Family Practice and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indication my choice to be a "No Information" and I do not want any information released to anyone else.

NAME	**RELATIONSHIP TO PATIENT**	**CONTACT INFO**

By my signature below I acknowledge that I have read and understand the Guidelines to Patient Communication and information provided on this consent form. I understand the risk associated with the different methods of communications, and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that Wattles Park Family Practice may impose.

____

Patient Name Printed Date

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Patient/Authorized Signature Relationship to Patient