Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

Medical Information Preferences

Patient _____ MR# _____ DOB _____ Practice: _____

As our patient, we may need to communicate with you when you are not in the practice. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care.

PLEASE INDICATE YOUR PREFERENCES

☐ 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 # - Extension
Home			
Answering Machine			
Work Phone			
Cell Phone			
Pager			

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.):

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☐ Do **not release medical information** to anyone other than myself.

☐ I give **permission to release medical information** pertaining tom me to the individuals listed below.

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

Comments

I assume 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.