COMMUNICATION OF PROTECTED HEALTH CARE INFORMATION

To include appointments, test results, billing information, etc.

The information on this form will be in effect for 1 year from the date signed. It is the patient/guardian responsibility to inform our office of need to amend this form.

Please initial and date the applicable statements below:	Initial	Date
I give Leawood Family Care permission to leave **non-specific information (nature of call only)** on voicemail or answering machine at my home or cell	_____	_____
I give Leawood Family Care permission to leave **specific medical information (test results/billing information/etc.)** on voicemail or answering machine at my home or cell	_____	_____
I give Leawood Family Care permission to call my cell phone	_____	_____

I give Leawood Family Care Permission to discuss my **medical care/billing concerns** with the following people:

_____ Print name of **ANOTHER INDIVIDUAL**

_____ Print name of **ANOTHER INDIVIDUAL**

_____ Print **PATIENT NAME**

_____ **PATIENT OR GUARDIAN SIGNATURE**

Date _____

Patient mailing address _____

_____

Home phone _____ Cell phone _____

Email address _____