

**Communication Authorization Form**

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

When it comes to your medical treatment, we strive to communicate with you in a timely and professional manner. There are certain occasions when family members, friends, or others might be involved in your care. As a patient, you will want our hospital to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of those individuals with whom we can discuss your care and share your protected health information.

Please list below those individuals with whom you authorize our office to discuss aspects related to your care.

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

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**Transportation**

If you are to receive anesthesia or intravenous sedation during your visit today, you must have a responsible adult available to receive discharge instructions and transport you home following your procedure or surgery. We also recommend you have a responsible adult available for twenty-four (24) hours post-operatively/post-procedure. Please list the person(s) in whose care you are being discharged today.

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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**Emergency Contact**

In the event of an emergency, please provide a person who we should contact.

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Admission Personnel: \_\_\_\_\_