P.L. Allen M.D.

Disclosure of Patient Information

(Please print)

Please list the family members or other persons, if any, whom we may inform about your **GENERAL MEDICAL** conditions and diagnosis (including treatment, payment, and health care options):

Name:_____ Phone: _____

Name:_____ Phone: _____

Name:_____ Phone: _____

Please provide alternative methods to contact you regarding your appointments, labs, x-ray results, or other health care information other than your home or work numbers. Be aware that a mobile phone is not a secure and private line.

Phone:_____ Email: _____

Do we have your permission to leave a message on your voice mail? Yes □ No □

FOR EMERGENCY SITUATIONS ONLY - Please list family members or other persons whom we may contact about your medical condition in the event of an emergency.

Name:_____ Phone: _____

Name:_____ Phone: _____

Patient Signature_____ Date: _____

Parent/Guardian signature_____

Acknowledgement of Review of Notice of Privacy Practices

(Please print)

I, _____, have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date