

**Diabetes and Thyroid Center of Fort Worth, PLLC
Darren Lackan, MD, PA _ Chris Bajaj, DO, PA**

PATIENT NAME: _____

ACCT#: _____

**PATIENT PREFERENCE REGARDING
COMMUNICATION OF HEALTH INFORMATION**

WHO TO CONTACT

I hereby give permission to Diabetes and Thyroid Center of Fort Worth, PLLC to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name		Relationship	
Name		Relationship	
Name		Relationship	

I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition(s).

HOW TO CONTACT

Communication by Phone

Home Telephone: ()		Work Telephone: ()	
<input type="checkbox"/>	Okay to leave message with detailed information	<input type="checkbox"/>	Okay to leave message with detailed information
<input type="checkbox"/>	Leave message with call-back number only	<input type="checkbox"/>	Leave message with call-back number only

Written Communication

<input type="checkbox"/>	Okay to mail to my home address:
<input type="checkbox"/>	Okay to mail to my work address:
<input type="checkbox"/>	Okay to fax to this number:

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient or
Parent/Guardian Signature: _____ Date: _____