Family Healing Center, PA
Dr. Christina Captain, AP, DOM

Consent for Communication and/or Disclosure

1. May our Patient Care Coordinator contact you:

   At home? Yes No
   If yes, may we leave the following information on your home voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

   At work? Yes No
   If yes, may we leave the following information on your work voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

2. Please indicate the number you wish us to use to contact you:
   Home:________________________ Work:_________________________ Cell:____________________

3. Please print the names of family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and heath care operation):

   o NONE
   Name____Phone__________________________
   Name____Phone__________________________
   Name____Phone__________________________

4. Please list family members or significant others, if any, whom we may inform about your medical condition ONLY IN CASE OF EMERGENCY:
   Name____Phone__________________________

5. Please print the address where you wish billing statements and/or correspondence from our office to be sent.
   o Use my home address
   o Use this one: ____

6. Do you require that all correspondence from our office be marked "CONFIDENTIAL"? Yes No

7. May we send you email messages, such as newsletters and Family Healing Center updates, events and specials?
   Yes, at this email____ No

I request the above alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Family Healing Center and give my permission to share the information as indicated with the person(s) named above.

PATIENT SIGNATURE ____***DATE***_____________________