



SARASOTA CENTER FOR ACUPUNCTURE & NUTRITION

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 health care operation):

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.

Use my home address

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 Sarasota Center for Acupuncture & Nutrition 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 Sarasota Center for Acupuncture & Nutrition and give my permission to share the information as indicated with the person(s) named above.

PATIENT SIGNATURE _____ DATE _____