HHO HUNTERDON BLOOD & CANCER SPECIALISTS

Patient Name:	DOB:

As our patient, we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential medical information such as lab and other test results to you and/or others involved in your care.

Please indicate your communication preferences below:

Method	Yes	No	Area code, Phone # E-Mail
Home telephone			
Home answering Machine			
Work phone			
Mobile phone			
E-Mail for Patient Portal			

Without specific permission, we will not release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relations to you (i.e. spouse, parent, child, partner caregiver)

- **Do not release medical information to anyone other than myself**
- **I give permission to release medical information pertaining to me to the individual(s) listed below**

Name	Relationship	Area Code, Phone # Extension

In case of emergency, who may we contact?

Name
Address
Telephone/Mobile phone

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or the intention to revoke this specific medical information authorization at any time.

_____ _____

Signature of Patient/Pt Representative **Date**

_____

(Please print Patient/Pt Rep name)