

FLORIDA PHYSICIANS
MEDICAL GROUP

**COMMUNICATION
USE AND DISCLOSURE AUTHORIZATION**

Section A: Please complete the following information for all requests

1. Today's date: _____
2. Patient name: _____
3. Date of Birth: _____ 4. Patient #: _____
5. Address: _____

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

1. You may leave the following messages on answering machines:
- Referral Information
 - Prescription refill information
 - Test results
 - Other: _____
2. You may discuss information regarding my treatment and care with the following family members and/or friends:
- _____
- _____
- _____
- _____
3. You may contact me regarding my treatment and care at the following numbers:
- _____
- _____
- _____
- _____

Signature of Patient or Guardian

Date

Signature of Staff Person and Title

Printed Name of Staff Person and Title