Advanced Healthcare Clinic, LLC
Acupuncture and Integrative Medicine

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 answering machine or 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 home answering machine or voicemail?

Appointment Information: ❑ Yes ❑ No Billing Information: ❑ Yes ❑ No Medical Information: ❑ Yes ❑ No

2. **Please indicate the number you wish us to contact you:**

Home: _____ Work: _____ Mobile/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):**

_____ _____
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 Name Phone

5. **Please print the address where you wish billing statements and/or correspondence from our office to be sent if other than your home:**

_____ _____ _____ _____
Street City State Zip Code

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 Advanced Healthcare Clinic updates, events and specials? ❑ Yes ❑ No**

If yes, please provide your email address: _____

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

_____ _____
Patient Name (Please print) Guardian's name if patient is under 18 years of age

_____
Patient/Guardian Signature