



Patient Name (printed)

Date of Birth

ALTERNATIVE COMMUNICATION RELEASE FORM

I authorize St. Anthony's Primary Care, LLC, in regards to my protected health information:

- ____ To call me at work
- ____ To call me at home
- ____ To call my cell phone
- ____ To speak with anyone listed on the Right To Share Information list
- ____ To only speak with me
- ____ To fax information to me at this secured number _____
- ____ Other _____

(Alternative address)

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

St. Anthony's Primary Care, LLC. reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy.

In order to have your PHI shared in other circumstances with members of your family or friends please list those individuals that we are authorized to release information.

Signature of Patient

Date

Witness

Date