

COMMUNICATION WITH FAMILY, OTHERS INVOLVED IN CARE

PATIENT IDENTIFICATION

Name: _____ D.O.B: _____

SSN: _____ Chart #: _____

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME	ALL	Scheduling/ Appointment	Medical	Billing/ Insurance
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specific Instructions or Limitations: _____

Validation Code: _____ Please provide this code to any individual who may be involved in coordinating your care or payment for care. They will ask for this code before information will be released over the phone.

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of patient/Legal Representative

Date

Relationship to patient: _____

Expiration Date

To revoke this authorization, please send a written request with a copy of this form to the address below.

**MEDICAL PARK FAMILY CARE, INC.
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ANCHORAGE, ALASKA 99502
PHONE (907)279-8486 FAX(907)257-8180**