PATIENT AUTHORIZATION TO COMMUNICATE FORM

I, _____, _____ *am requesting that Oakleaf Clinics, SC*
(Patient Name) (date of birth)

communicate future information regarding my health care and/or billing account to me in the following manner:

Mail invoices or statements to:

_____

_____

_____

Health care information and or billing information may also be released to and/or discussed with the following person(s):

_____
(Name) (relationship to patient)

_____
(Name) (relationship to patient)

I prefer to be contacted:

ϕ By phone:_____ Circle one: Home Work Cell Other
Area Code/Telephone Number

_____ Circle one: Home Work Cell Other
Area Code/Telephone Number

ϕ May leave message ϕ Do Not leave message

ϕ Patient Portal (Electronic Communication)

Patient/Personal Representative Signature: _____ Date: ___/___/___

Received by _____ Date: ___/___/___

This authorization is valid until _____, or until I choose to revoke it.
(date)