Patient Record of Disclosures

I wish to be contacted in the following manner:

Home telephone:_____________________________

____ OK to leave message with detailed information

____Leave message with call-back number only

Work telephone:____________________________

____OK to leave message with detailed information

____Leave message with call-back number only

____Do not call at work

Written Communication

____OK to mail my home address

____OK to mail my work/office address

____OK to fax to this number

Names of people we are allowed to release information to:

________________________ ________________________

________________________ ________________________

________________________ ________________________

_________________________ _______________________

Patient Signature Date

_________________________ ________________________

Print Name Birth date