South Point Family Practice, PA

Communication Form

I ___________________________ give permission for South Point Family Practice to share my medical information with the following people who are involved with my care..

I understand that if someone is “not listed” they will not be advised of my appointments, referrals, medical information, billing information, test and/or lab results.

(If you choose for no one to have this information, please write in “No one” and sign this form)

Name	Phone Number	Relationship
___________________________________	________________________	__________________
___________________________________	________________________	__________________
___________________________________	________________________	__________________

If I am not available and my answering machine or voice mail answers for me, SPFP has my permission to leave a message advising me of my appointments, referrals, medical information, test and or lab results.

☐ Yes ☐ No

Date: ___/___/______

X____

Patient / Guarantor Signature

Patient DOB: ___/___/______

Acknowledgement of receipt of Joint Notice of Privacy Practices:

I have received a copy of South Point Family Practice Notice of Privacy Practices.

Date: ___/___/______

X ____

Patient / Guarantor Signature