Doctors Care
Accessible Care for the Underserved

Account #:_____

Contact Consent Form

Your Protected Health Information (PHI) is confidential and protected by Doctors Care.

Please tell us how you would like us to contact you:

Home Phone:	Brief Message	Y/N
_____	Detailed Message	Y/N
Cell Phone:	Brief Message	Y/N
_____	Detailed Message	Y/N
Work Phone:	Brief Message	Y/N
_____	Detailed Message	Y/N

Email: _____

This will not sign you up for the Patient Portal. We will not send Protected Health Information to this email address.

Please list below any individuals whom you wish your/your child's health information to be released to:

Name/Telephone Number/Relationship:	Brief Message	Y/N
_____	Detailed Message	Y/N
Name/Telephone Number/Relationship:	Brief Message	Y/N
_____	Detailed Message	Y/N

I authorize and request Doctors Care to share information with and get information from the following people. This information could include requesting my complete medical records, reminders of appointments, status of specialist referrals, lab results, history and physical, progress notes, discharge summary, X-rays films/reports, billing record, itemized bills and financial information. This could include information related to your behavioral health, sexual health, substance use disorders, and other sensitive information.

This is not an authorization for this individual to consent to treatment or accompany a minor during a visit. I understand that I can change this information at any time and that this authorization will expire one year from now.

_____ _____

Name of Patient **Date**

_____

Signature (patient or parent/guardian if minor)