FLORIDA PHYSICIANS
MEDICAL GROUP

THE SKILL TO HEAL. THE SPIRIT TO CARE.

COMMUNICATION
USE AND DISCLOSURE AUTHORIZATION

Section A: Please complete the following information for all requests

1. Today's date: ______________________
2. Patient name: ______________________
3. Date of Birth: ______________ 4. Patient #: ______________

4 . Address: ______________________

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

1. You may leave the following messages on answering machines
   - ☐ Referral Information
   - ☐ Prescription refill information
   - ☐ Test results
   - ☐ Other: ______________________

2. You may discuss information regarding my treatment and care with the following family members and/or friends:

   ____
   ____
   ____
   ____

3. You may contact me regarding my treatment and care at the following numbers:

   ____
   ____
   ____
   ____

______________________ ______________
Signature of Patient or Guardian Date

____
Signature of Staff Person and Title

____
Printed Name of Staff Person and Title