

**WILLOWBEND HEALTH & WELLNESS ASSOCIATES**

**Phyllis Gee, M.D.     Natalie Settele, PA-C**

**Contact Information**

Patient Name: \_\_\_\_\_

**Patient Preference Regarding Communication of Health Information**

**How to Contact**

I wish to be contacted in the following manners pertaining to my health care:

Home Telephone: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

Mobile Telephone: \_\_\_\_\_

\_\_\_\_ OK to leave a message with detailed information

\_\_\_\_ OK to leave a message with detailed information

\_\_\_\_ Leave a message with a call-back number only

\_\_\_\_ Leave a message with a call-back number only

\_\_\_\_ Written Communication

\_\_\_\_ OK to mail to my house address: \_\_\_\_\_

\_\_\_\_ OK to mail to my work/office: \_\_\_\_\_

\_\_\_\_ OK to fax to this number: \_\_\_\_\_

\_\_\_\_ I agree to receive general information e-mails from Willowbend Health & Wellness.

**Who to Contact**

I hereby give permission to Dr. Gee's office to disclose and discuss any information related to my medical information to/with the following family member(s), other relative(s) and/or close personal friends(s):

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition (s).

I hereby give permission to Dr. Gee's office to disclose and discuss any information related to my medical information to/with the following Physicians and/or other Healthcare Professionals:

\_\_\_\_\_  
Physicians Name

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Phone #

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific Authorization prior to the disclosure of any information.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date