Communication Authorization

____________________________________ _____________________
Patient Name Date of Birth

I, ____ give Frederick Primary Care
(Patient's Name)
Associates, P.A. permission to discuss the following:

- ☐ Diagnosis, prognosis, and/or treatment information
- ☐ Test results
- ☐ Scheduling information
- ☐ Billing information
- ☐ Other (please specify): ____________________________________

With the following people:

________________________ Relationship: ____________ Phone #: ____________

________________________ Relationship: ____________ Phone #: ____________

________________________ Relationship: ____________ Phone #: ____________

I also authorize Frederick Primary Care Associates, P.A. to:

- ☐ Leave messages on my home answering machine
- ☐ Leave messages on my work answering machine/voice mail
- ☐ Leave messages with my family members or others residing in my household

Patient Signature: __________________________________ Date: ________________

For Minors Only:

Signature: ____ Date: ________________
Parent or Legal Guardian

Note: This form must be filled out completely in order for Frederick Primary Care Associates (FPCA) to ensure the privacy and confidentiality of our patients' protected health information. The instructions on this form will be considered current until a new Communication Authorization supersedes them. It is the patients' responsibility to file a new form with FPCA if there are changes in your household situation. FPCA is not responsible for undesired communications resulting from the failure of a patient to file a new Communication Authorization form.