PATIENT COMMUNICATION DIRECTIVE WITH INDIVIDUALS INVOLVED IN YOUR CARE

ORIGINAL WILL BE SCANNED INTO YOUR MEDICAL RECORD

PATIENT IDENTIFICATION

NAME____

ADDRESS____

DATE OF BIRTH____________________PHONE_____________________CELL___________________

EMAIL____

PLEASE LIST ALL INDIVIDUALS WITH WHOM WE CAN COMMUNICATE WITH REGARDING YOUR APPOINTMENTS, TREATMENT OR ACCOUNT INFORMATION

NAME	**RELATIONSHIP TO PATIENT**
______________________________________	____________________________________
______________________________________	____________________________________
______________________________________	____________________________________
______________________________________	____________________________________

NOTE: We will continue to rely on the information on this form when communicating with family members or other involved in your care unless you request changes. Please promptly notify us if you wish to alter the designations above.

SIGNATURE OF PATIENT____

LEGAL REPRESENTATIVE____

DATE____

RELATIONSHIP TO PATIENT____

TO REVOKE THIS AUTORIZATION, PLEASE SEND A WRITTEN REQUEST TO:

Belinda Lankford

Morse & Doyle, DDS, PA

633 Hopkins Road

Kernersville, NC 27284