# ALTERNATIVE COMMUNICATIONS FORM

(Alternative Ways for us to communicate with you)

*Flagel Pediatric & Family Medicine*

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*Board Certified, Family Medicine*

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*Board Certified, Pediatrics*

Patient's Name: ________________________ Birthdate: ________ Date: __________

**Complete all that applies:**

**I give permission for the following person(s) to discuss my health information with staff & physicians at Flagel Pediatric & Family Medicine**: __________________________________________________

_________________________________________________________________________________

**I give permission to be contacted at any of the following phone numbers regarding messages or results for myself or my minor children:**

Home: ___________________________ Work: ______________________________

Cell: ______________________________Fax: ______________________________

Other (please specify): ________________________________

**I give permission to (please mark all that apply):**

[ ] Leave messages/results on answering machine (messages will not be left on an unidentified answering machine)

[ ] Leave messages/results with a family member

Please specify family member and relationship ___________________________________

Phone number of family member if not living with you _____________________________

**This form of communication will be used as the standard form of communication until I revoke this in writing.**

Patient Name: ________________________________________ Date of Birth: ______________________

Patient/Guardian Signature: ________________________________________________________________

Date Signed: ______________________________ Staff initials: _________________________________