Osteopathic Healthcare of Maine

PATIENT NOTIFICATION FORM

Patient's Legal Name: _____ D.O.B. _____
First MI Last

Patient's Mailing Address: _____

If applicable, name of parent(s), legal guardian(s): _____

		Circle One		**Circle One**
Cell (_____) _____	Okay to leave message?	Yes / No	**Detailed Message?	Yes / No
Home (_____) _____	Okay to leave message?	Yes / No	**Detailed Message?	Yes / No
Work (_____) _____	Okay to leave message?	Yes / No	**Detailed Message?	Yes / No

***Detailed messages may contain medical and/or prescription information*

Patient's Marital Status: Single Married Divorced Widowed

Patient's Primary Care Physician: _____

Patient's Employer: _____ Occupation: _____

Health Insurance Company: _____ Policy Number: _____

Emergency Contact: _____ Relationship: _____

Emergency Telephone: Cell (____) _____ Home (____) _____ Work (____) _____

Select One:

☐ I do <u>not</u> want any information about my healthcare communicated to family members/caregivers.

☐ I give Osteopathic Healthcare of Maine permission to verbally communicate to family members/caregivers listed below.

Name: _____ Name: _____ Name: _____

Please check the box next to the specific information that may be **<u>verbally</u>** communicated to the individual(s) listed above:

☐ Prescription Request ☐ Request/Confirm/Cancel Appointments

☐ Referral Request ☐ Other (specify): _____

This authorization expires 12 months from the date hereof. I have the right to revoke this authorization in writing at any time. Revocation will not cover information/material released prior to that date, but will present further release of information.

If you would like to grant permission to Osteopathic Healthcare of Maine to discuss AIDS/HIV, Alcohol and/or Drug Abuse, or Mental Health with anyone but yourself, please request a *Medical Release Form.*

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____