Endocrine Consultants of Texas
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COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE

This form allows you, as the patient, to choose those persons you want to include and allow access to your medical information. This communication can be changed or voided by you at any time;however, we can not retrieve the information that has already been shared.

Name:_____ Date of birth:_____
SSN: _____

Please list any family members or others who may be involved in coordinating your care. Also, please indicate what kind of information may be shared with each person listed.

Name	Relationship to Patient	All	Appointment	Medical	Billing
_____		☐	☐	☐	☐
_____		☐	☐	☐	☐
_____		☐	☐	☐	☐
_____		☐	☐	☐	☐

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request change. Please promptly notify our office if you wish to alter the designations above.

_____ _____
Signature of Patient /Legal Representative Date

Relationship to the patient_____

To revoke this consent, please send a written request to the address at top of form.