

This Section To Be Filled Out By IOC	Medical Record # _____
	IOC Staff Initials: _____

Patient name: _____
(Please print)

Date of Birth: _____

Contact Information:

In an effort to effectively reach you regarding medical appointments, medical care, lab results, etc..., please list your contact information (must have at least one):

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Home: _____ | <input type="checkbox"/> Fax: _____ |
| <input type="checkbox"/> Work: _____ | <input type="checkbox"/> Email: _____ |
| <input type="checkbox"/> Cell: _____ | <input type="checkbox"/> Other (specify): _____ |

Release of Information:

I do not want any other person to have access to my appointments and medical care. Note: Release of medical records requires a separate and specific form from this one. This is required for each incident of record release.

I give permission for the following person(s) to receive information regarding my appointments and medical care. Note: Release of medical records requires a separate and specific form from this one. This is required for each incident of record release.

NAME	PHONE	RELATIONSHIP	EMERGENCY CONTACT
1. _____	_____	_____	<input type="checkbox"/>
2. _____	_____	_____	<input type="checkbox"/>
3. _____	_____	_____	<input type="checkbox"/>
4. _____	_____	_____	<input type="checkbox"/>
5. _____	_____	_____	<input type="checkbox"/>

I give my permission to:

- Leave message/results on an answering machine
(Medical information will not be left on an unidentified answering machine)

This form of communication will be used as the standard until revoked in writing by patient or we have an updated form on file.

Is this patient a minor? Yes No If patient is a minor, this form must be completed and signed by a parent or guardian.

Patient/Guardian Signature: _____

Date signed: _____