

Lehigh Valley Physician Group  
**Medical Information Preferences**

Patient \_\_\_\_\_ MR# \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care.

**PLEASE INDICATE YOUR PREFERENCES**

I give permission to leave **medical information** pertaining to me, my dependent or my minor child, at the numbers listed below:

Method	Yes	No	Area Code, Phone # - Extension
Home			
Answering Machine			
Work Phone			
Cell Phone			
Pager			

**Without specific permission**, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

Do not release **medical information** to anyone other than myself.

Name	Relationship (i.e. spouse, parent, son, daughter, etc.)	Area Code, Phone # - Extension

Comments

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific of medical information authorization at any time.