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Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

## ***Alternative Communication Release Form***

Right to share information with family and Friends

I authorize VMedcare, in regard to my protected health information (PHI):

- To fax information to me at this secured number \_\_\_\_\_
- To call me at work
- To call me at home
- To call my cell phone
- To speak with anyone listed on the right to share information list
- To only speak with me
- To send me email at the following address \_\_\_\_\_

Alternative address \_\_\_\_\_

VMedcare reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in Notice of Privacy.

In order to have your PHI shared in other circumstances with members of your family or friends please list those individuals that we are authorized to release information.

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Signature of patient \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_