COMMUNICATION AUTHORIZATION

Patient Name:_____ Date of Birth:_____

POSA will communicate with you via the following methods:

- ❖ Home telephone
- ❖ Work telephone
- ❖ Cellular telephone voice and text
- ❖ Written communication to home address
- ❖ Written communication via email
- ❖ Written communication to fax number

☐ **I do not wish to be communicated with via the following method(s)_____ or have other restrictions to include:_____**

_____*(initial)* **I give permission for POSA to share social media posts to our Facebook page/Google/Yelp/ Health Grades or tagged with our page or location.**

You may discuss my health care needs with the following individual(s), i.e. stepparent, other family members, school, neighbors, nannies, etc. (do not include physicians).

Name of Individual:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

_____ _____
Patient or Legal Guardian Signature Date

_____ _____
Above information reviewed and no changes - Signature Date

_____ _____
Above information reviewed and no changes – Signature Date

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