Dr. Arthur Stember
408 5th Avenue
Indialatic, FL 32903

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider.

Do we have permission to:

Call you at home? ☐Yes ☐No
If yes, can we leave the following information on your home answering machine or voice mail?

Appointment Information?	☐Yes	☐No
Billing Information?	☐Yes	☐No
Medical Information?	☐Yes	☐No

Can we call you at work? ☐Yes ☐No
If yes can we leave the following information on your work answering machine or voicemail?

Appointment Information?	☐Yes	☐No
Billing Information?	☐Yes	☐No
Medical Information?	☐Yes	☐No

I give my permission to share the following information with the person(s) named below.

Name:_______________________ **Relationship**_______________________
Appointment ☐Yes ☐No **Billing** ☐Yes ☐No **Medical** ☐Yes ☐No

Name:_______________________ **Relationship**_______________________
Appointment ☐Yes ☐No **Billing** ☐Yes ☐No **Medical** ☐Yes ☐No

Name:_______________________ **Relationship**_______________________
Appointment ☐Yes ☐No **Billing** ☐Yes ☐No **Medical** ☐Yes ☐No

Name:_______________________ **Relationship**_______________________
Appointment ☐Yes ☐No **Billing** ☐Yes ☐No **Medical** ☐Yes ☐No

_______________________ _______________
Patient Signature **Date**

_______________________ _______________
Witness Signature **Date**