Communication with Family, others Involved in Care for:
Family Physicians Group, P.C. 770 N Cortner Blvd Suite 205 Lincoln, NE 68505

PATIENT IDENTIFICATION:

Legal Name:_____ Date of Birth:_____

S.S.#_____

Please list any family members or others who may be involved in coordinating your care of payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME/PHONE # AND RELATIONSHIP TO PATIENT:	All	Scheduling/Appts	Billing/Insurance	Medical
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____

_____ **Messages may be left if pt unavailable**

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify Family Physician's Group, P.C. if you wish to alter the designations above.

Signature of Patient/
Legal representative:_____ Date: _____

Relationship to Patient: _____

To revoke this authorization, please send a written request with a copy of this form to the address below:

Family Physicians Group, P.C.
770 N Cotner Blvd Suite 205
Lincoln, NE 68505-2344
402-467-4661

Signed original will be placed in your chart. If you want a copy for your records please ask a receptionist.

Updated 10/18/2013