

Junior De Freitas, M.D.

Dr. De Freitas and his staff are often in position to speak with persons other than you, regarding your appointments and healthcare.

Please read the statements below and indicate YES or NO to give your consent.

I consent to having messages regarding my appointments and/or healthcare, as necessary:

- Yes No Left on my home voicemail
- Yes No Left on my office voicemail
- Yes No Left with another person at my home
- Yes No Mailed to my home
- Yes No Discussed directly with me over the phone

I give my consent for Dr. De Freitas and his staff to discuss my health information, as may be necessary, with the following people (please write the name of each person on the appropriate line):

- Primary care doctor: _____ Phone #: _____
- Spouse: _____ Phone #: _____
- Parent: _____ Phone #: _____
- Children: _____ Phone #: _____
- Other: _____ Phone #: _____

My signing of this form DOES NOT authorize release of written information. I understand that if information is requested, I must sign a separate authorization form for the release of written information as stated in the Notice of Privacy Practices. A copy of the Notice of Privacy Practices has been provided for me by the physician; I have read and understand all that it entails.

Patient / Guardian Signature	Relationship	Date
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Print Patient Name