PATIENT DISCLOSURE INSTRUCTIONS
John A. Schmidt, Jr., M.D. LLC

SECTION A: PATIENT INFORMATION

Name:____

Address: ____

Date of Birth: __________________________ **Social Security #**__________________________________

SECTION B: I WISH TO BE CONTACTED AS FOLLOWS:

Home/Cell Phone #:_______________________ **Home Email address:**_____________________________

Work phone #:__________________________ **Work Email address:** _____________________________

Unless otherwise instructed, a message with only the Doctor's name and number will be left. Check if we have your permission to leave a detailed message on your:

___home/cell voicemail,

___ home email,

___work voicemail, and/or

___work email.

All written communication will be mailed to your home address on file and marked confidential.

SECTION C: I AUTHORIZE SHARING MY PROTECTED HEALTH INFORMATION WITH THE FOLLOWING PERSONS (PLEASE LIMIT TO TWO OR WRITE "NONE"):

NAME/RELATIONSHIP/DOB: ____

TELEPHONE#_________________________

NAME/RELATIONSHIP/DOB: ____

TELEPHONE#_________________________

Signature: _____________________________________ **Date:** _________________________________

Print name: ___________________________________ **Title:** _________________________________

This form will become part of the Patient's records.