FAMILY ALLERGY CENTER

13890 BRADDOCK ROAD, SUITE 206 CENTREVILLE VA 20121
14535 JOHN MARSHALL HIGHWAY, SUITE 212 GAINESVILLE VA 20155

Kenneth R. Bergman, M.D.
Tamara S. Smith, M.D.
Catherine Thal-Larsen, F.N.P

COMMUNICATION PREFERENCE

PATIENT NAME _____ DATE OF BIRTH_____

PLEASE INDICATE WHICH OF THE FOLLOWING NUMBERS YOU WOULD LIKE US TO USE:

□ HOME PHONE_____

□ WORK PHONE_____

□ CELL PHONE _____

□ E-MAIL*_____

** E-MAIL ADDRESSES WILL ONLY BE USED TO PROVIDE NON-CONFIDENTIAL OFFICE UPDATES OR NEWS LETTERS. WE WILL **NOT** PROVIDE PERSONALIZED COMMUNICATIONS, INCLUDING APPOINTMENT REMINDERS VIA E-MAIL.*

IN REGARD TO MESSSAGES LEFT ON VOICEMAIL OR AN ANSWERING MACHINE, YOU AUTHORIZE FAMILY ALLERGY CENTER (PLEASE CHOOSE ONE):

□ TO LEAVE MESSAGES REGARDING YOUR MEDICAL CONDITION(S), AS WELL AS APPOINTMENT REMINDERS, BILLING/FINANCIL QUESTIONS, AND REQUESTS TO CALL THE OFFICE.

□ TO LEAVE ONLY MESSAGES REGARDING APPOINTMENT REMINDERS AND REQUESTS TO CALL THE OFFICE.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME_____ DATE OFBIRTH_____

THE PERSON NAMED ABOVE HEREBY AUTHORIZES PROTECTED MEDICAL INFORMATION (THIS INCLUDES ALL INFORMATION REGARDING ASSESSMENT, DIAGNOSIS, AND TREATMENT OF PATIENT'S CONDITION, CONCERN, OR DISEASE) TO BE REQUESTED OR RELEASED TO THE FOLLOWING INDIVIDUAL(S):

1. _____ RELATION TO PATIENT: _____

2. _____ RELATION TO PATIENT: _____

□ I DO NOT AUTHORIZE MY PROTECTED HEALTH INFORMATION TO BE REQUESTED OR RELEASED BY ANY INDIVIDUAL.

I UNDERSTAND I MAY NOTIFY THE DOCTOR'S OFFICE AT ANY TIME OF CHANGES TO THIS FORM, WHICH WOULD REQUIRE A NEW FORM AND AUTHORIZATION TO BE COMPLETED.

SIGNATURE _____ DATE_____