MAYO PRACTICE ASSOCIATES
897 WEST MAIN STREET
DOVER FOXCROFT, ME 04426

PATIENT DIRECTIVES CONCERNING COMMUNICATING ABOUT HEALTH INFORMATION

We ask that you please take a moment and read the following information sheet. Please give your consent to the providers at Mayo Practice Associates regarding the following issues:

To whom may we release medical information regarding your health and/or treatment: (please circle response)

Spouse Yes Name____________________________________ phone #____________________

No

Child/children Yes Name(s)__________________________________ phone #____________________

No

Parent Yes Mother? Name_____________________________ phone #____________________

Father? Name______________________________ phone#____________________

No

Any Relative Yes Name_____________________________________ phone #______________________

No

Please specify if other ___________________________________ phone #:_____________________

Other special instructions?

Where may we contact you?

Home Yes phone #__________________________ No

Cell phone Yes phone # __________________________ No

Work Yes phone #__________________________ No

Other ? (please specify) ____

May we leave a message regarding your care on your home answering machine?
yes no

Signed: ______________________________________ Date _______________________________

This communication will be in effect until rescinded in writing.