

**Allergy & Asthma Consultants of Montana, P.L.L.C.**

**COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE**



**EMERGENCY CONTACT:**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Best telephone # \_\_\_\_\_  Home  Cell  Work Other telephone # \_\_\_\_\_  Home  Cell  Work

**MAY WE DISCUSS THE PATIENT'S MEDICAL CARE WITH THIS PERSON?**  Yes  No

**FOR MINOR PATIENTS:**

Mother's name \_\_\_\_\_ Best telephone # \_\_\_\_\_  Home  Cell  Work

Address (if different than patient) \_\_\_\_\_

Father's name \_\_\_\_\_ Best telephone # \_\_\_\_\_  Home  Cell  Work

Address (if different than patient) \_\_\_\_\_

**MAY WE DISCUSS THE PATIENT'S MEDICAL CARE WITH BOTH PARENTS?**  Yes  No

**NAME(S) OF ANYONE ELSE WITH WHOM WE MAY DISCUSS THE PATIENT'S CARE**

**Please include:**

- **insurance holder if other than the patient**
- **your primary care doctor**

\*Note: We will not discuss care with anyone other than a physician unless they are listed here.

NAME:	RELATIONSHIP TO PATIENT:	TYPE OF INFORMATION:			
		ALL	SCHED/APPT	MEDICAL	BILLING
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Patient/Guardian: \_\_\_\_\_ Date : \_\_\_\_\_

Relationship to Patient : \_\_\_\_\_

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. To revoke this authorization, please submit a written request to Allergy & Asthma Consultants of Montana, PLLC.