

Communication Permissions - Adult

Patient Name: _____

Date of Birth: _____

SECTION 1
Mosaic may leave a voicemail for the following: (check all that apply)

- General information regarding your care
 Billing
 No Messages of any kind
 Use: Preferred Number on file **ONLY**
 Any Personal Number on file (not including emergency contact)

Mosaic will use automated calls or texts for appointment reminders and other clinic notifications such as clinic closures, etc. **By checking this box** you agree to receive these automated reminders and notices at your preferred number on file.

SECTION 2

Let us know who we may communicate with regarding your care. Specify what type of information we may share. (Examples: caregiver/care facility, spouse, family member who is not a legal representative, guardian, power of attorney, etc.)

I authorize Mosaic to communicate with the following people in person or by telephone in order to: (check all that apply)

Name: _____ **Relationship:** _____ **Phone:** _____

- Discuss **ALL** information
NOTE: this is not an authorization to release records.
 Pick up items from clinic. (Including medication, correspondence, hardcopy scripts, etc.)
 Appointment Management
 Other: _____

Name: _____ **Relationship:** _____ **Phone:** _____

- Discuss **ALL** information
NOTE: this is not an authorization to release records.
 Pick up items from clinic. (Including medication, correspondence, hardcopy scripts, etc.)
 Appointment Management
 Other: _____

NOTE: If you would like to add more people to this section, please do so on the back of the page.

SECTION 3

Does the patient have a legal representative, guardian, medical power of attorney, etc.?

If so, please list them and provide the legal documentation for our records.

None

Name: _____ **Relationship:** _____ **Phone:** _____

SECTION 4

Signature required (below):

The authorization may be changed or revoked in writing at any time. It will remain in effect until that time.

By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

Signature (Patient/ Legal Guardian): _____ **Date:** _____

Print name (Patient/ Legal Guardian): _____ **Relationship:** _____