DR. DIANA GOROKHOVSKY PA

FAMILY AND FRIENDS CONTACT FORM

Patient Name:_____ DOB_____

By signing this paper below, I give permission to the person(s) listed in the table below to receive information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Name of Individual	**Relationship to Patient**	**Patient / Guardian Initials**

What is the best way for us to contact you ?

	Phone Number	**Description (Cell, Home, ETC..)**
Primary		
Secondary		
Tertiary		

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Print Name