

**Central Lambton Family Health Team**  
**Consent for Communication with Office**

This form allows you specify your communication preferences. It also allows you to name a person to communicate with the CLFHT on your behalf. Your medical information may only be relayed to you or your authorized contacts as indicated below.

**Section A. Your Information**

Name : \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Preferred Phone Number: \_\_\_\_\_  
Secondary Phone Number: \_\_\_\_\_

Can we leave information on voicemail?    Y    or    N ... If so,  
Information that can be left on the voicemail: \_\_\_\_\_

- Appointment dates and times from any health care provider
- Test Results,
- Follow Up health instructions
- Other: \_\_\_\_\_
- Exclusions: \_\_\_\_\_

**Section B. Authorized Contacts**

If the office is unable to reach me, I give them permission to contact the following individuals:

<b>Contact #1 -</b>	
Name: _____	Phone #: _____
Information that can be shared: _____	
<input type="checkbox"/>	Appointment dates and times from any health care provider
<input type="checkbox"/>	Test Results
<input type="checkbox"/>	Follow Up health instructions
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Exclusions: _____
<b>Contact #2 -</b>	
Name: _____	Phone #: _____
Information that can be shared: _____	
<input type="checkbox"/>	Appointment dates and times from any health care provider
<input type="checkbox"/>	Test Results
<input type="checkbox"/>	Follow Up health instructions
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Exclusions: _____

**Section C. Order of Contact (please number 1,2 or 3)**

Myself: \_\_\_\_    Contact #1: \_\_\_\_    Contact #2: \_\_\_\_

The Following people are allowed to book appointments on my behalf:

\_\_\_\_\_

The Following people are allowed discussions in office on my behalf:

\_\_\_\_\_

**Signed** \_\_\_\_\_

**Date:** \_\_\_\_\_