NEW MILFORD
MEDICAL GROUP

AGREEMENT FOR SHARING AND COMMUNICATION OF PHI

Please provide us with the name of who we may contact in the event of an emergency:

Name of Emergency Contact _____ Relationship and Phone Number(s) _____

*****Please repeat name below if we may also discuss your medical information with this person*****

In addition, I give permission for NMMG to discuss my medical information with the following people:

Name _____ Relationship and Phone Number _____

Name _____ Relationship and Phone Number _____

Name _____ Relationship and Phone Number _____

Name _____ Relationship and Phone Number _____

I give permission for NMMG to contact or leave messages for me by some or all of the following methods:

____Authorized person as noted above ____Cell phone

____Home phone ____Email or Patient Portal

Patient Name (Print) _____ Patient Date of Birth _____

Signature of Patient or Authorized Person _____ Date _____

Relationship of Authorized Person to Patient _____ Reason Patient Unable to Sign _____

Provided By HCP