Women's Clinic of Lincoln, P.C.
220 Lyncrest Drive Lincoln, NE 68510

Authorization to Communicate with Family, Others Involved in Care

Patient Name:_____DOB:_____

Account #_____

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate phone number and what kinds of information may be shared with each individual.

			TYPE OF INFORMATION			
Name:	Phone Number:	Relationship to patient:	All	Scheduling/ Appointment	Medical	Billing/ Insurance
_____	_____	_____	O	O	O	O
_____	_____	_____	O	O	O	O
_____	_____	_____	O	O	O	O
_____	_____	_____	O	O	O	O
_____	_____	_____	O	O	O	O

Specific Instructions of Limitations:_____

_____

We will continue to rely on the information on the form when communication with family members or other involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/ Legal Representative:_____**Date:**_____

Relationship to Patient:_____

To revoke this authorization, please send a written request to us. If you have any questions, please call Women's Clinic of Lincoln at (402)434-3370.

You may request a copy of this authorization.

For Office Use Only

____**Copy of Medical Power of Attorney in Chart**

10/2015 bm