Thomas E. Bowser, M.D., PLLC

COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR HEALTHCARE

PATIENT IDENTIFICATION:

Name: ____
Date of Birth: ____
Social Security Number: ___________________________________

Please list any family member or others who may be involved in managing your care of payment of care. Also, indicate what information may be given to each individual.

NAME	RELATIONSHIP TO PATIENT	TYPE OF INFORMATION			
		ALL	SCHEDULING	MEDICAL	BILLING
______________________	__________	☐	☐	☐	☐
______________________	__________	☐	☐	☐	☐
______________________	__________	☐	☐	☐	☐
______________________	__________	☐	☐	☐	☐
______________________	__________	☐	☐	☐	☐
______________________	__________	☐	☐	☐	☐

We will continue to rely on information on this form when communicating with family members or others involved with your care unless you request changes. Please promptly notify our office if you wish to alter the above list.

Signature of Patient/
Legal Representative:_____________________________ Date:________________

Relationship to Patient: ____

To revoke this authorization, please send a written request with a copy of this form to our address:

Thomas E. Bowser, M.D., PLLC
4105 Briargate Parkway, Suite 105
Colorado Springs, CO, 80920

For questions call our office at (719) 637-8444