



JACK ZOLDAN, M.D., LTD

BOARD CERTIFIED INTERNAL MEDICINE
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**COMMUNICATION/
EMERGENCY CONTACT INFORMATION**
Authorization for Communication with Members of Your Family and/or Other Individuals

I, _____, hereby request *Jack Zoldan, M.D., LTD* to keep
(Name of Patient or Patient Representative)
communications regarding my protected health information confidential. To accomplish this please
adhere to the following requests:

Phone: Leave messages on answering machine at **HOME:** **YES** **No** **TEL:** (____) _____

If **NO**, please explain: _____

Leave messages on answering machine at **WORK:** **YES** **No** **TEL:** (____) _____

Call and leave messages on **CELL PHONE:** **YES** **No** **TEL:** (____) _____

Mail: Contact me at the following address: _____

FAX: **YES** please contact me by FAX at (____) _____
 No please do not contact me by FAX

I authorize *Jack Zoldan, M.D., LTD* to verbally release any or all information concerning my medical care to the following individuals: (Please list below.)

_____ Name (Please Print)	_____ Relationship	_____ Daytime Telephone No.
_____ Name (Please Print)	_____ Relationship	_____ Daytime Telephone No.
_____ Name (Please Print)	_____ Relationship	_____ Daytime Telephone No.
_____ Primary Care Doctor (Please Print)		_____ Office Telephone No.
_____ Patient Name (Please Print)		_____ Date of Birth
_____ Signature of Patient		_____ Date
_____ Signature of Patient Representative if Patient is Unable to Sign		_____ Date
_____ Name of Representative (Please Print)	_____ Relationship of Patient Representative to the Patient (Please Print)	

Reason the Patient is Unable to Sign (Please Print)