Owensboro Health

Patient Identification:

Name _____ Date of Birth _____

Owensboro Health Medical Group (OHMG)
Communication with Family and Others Involved In Your Care

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kind of information may be shared with each individual listed on this form.
This form applies to any and all offices, clinics, and care providers where you receive services within OHMG.

Name	Relationship to Patient	All	Scheduling/ Appointments	Medical	Billing/ Insurance

We will continue to rely on the information on this form when communicating with family members or others 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: _____

Date: _____