DR SCOTT SELBY LLC

207 N. Washington Street
Wheaton IL 60187

COMMUNICATION CHOICES

Please List Your Preferred Numbers:	Type (Please Circle)	Appointment Reminders?	Leave Detailed Message Lab/Test results?
Primary Phone Number	Home Work Cell	Yes No	Yes No
Secondary Phone Number	Home Work Cell	Yes No	Yes No

* Answering machines and voice mail must have an identifying message to confirm these are your numbers for example; "You have reached John Doe"

CONSENT FOR VERBAL RELEASE OF INFORMATION

Please list any persons with whom we MAY share details about your health care including sensitive health information (SHI) such as mental health, Drug/Alcohol abuse.

NAME	RELATIONSHIP NOTE: EMERGENCY CONTACT AS "EC"	PHONE NUMBER

I understand that this consent is valid until it is revoked by me and applies to information about me obtained through Dr Scott Selby LLC physicians. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signature: ____ Date: ____________________

Printed name: ____

Relationship to patient: _________________________________