Cypress Physicians Assoc.
1250 Cypress Station #b
Houston, TX 77090

Confidential Communication Request

Home Phone Number: (answering machine)_____

Work Phone Number: (answering machine)_____

Cell Phone Number: (voice mail) _____

E-Mail Address: _____

☐ **I give permission for Cypress Physicians Assoc. to release (or leave a message regarding) any of my medical information with the following person(s) at the number(s) indicated.**

Name:_____ Phone Number:_____

Relationship:_____

Name:_____ Phone Number:_____

Relationship:_____

Name:_____ Phone Number:_____

Relationship:_____

Name:_____ Phone Number:_____

Relationship:_____

☐ **I do not give permission for Cypress Physicians Assoc. to release any medical information unless it is directly to me.**

Patient name (printed):_____ DOB:_____

Signature: _____ Date:_____
(Patient or person authorized to give consent)