Patient Communication Form

Patient Name _____ **MR#**_____ **ACCT #**_____ **DOB** _____

As a patient in our practice, from time to time we may need to communicate with you when you are not in the practice. To preserve your privacy, we would like for you to indicate your preferred method for us to communicate medical information to you, and to others involved in your care. Examples of medical information include your test results or appointment reminders, and are clinical in nature.

Without specific permission we will not release any of your medical information to another person. In some cases you may wish for another person to have access to your medical information. Can you please identify those individual(s) and their relationship to you (i.e., spouse, parent, son, daughter, etc.):

NAME	*RELATIONSHIP*
_____	_____
_____	_____

In the event that no one is available to answer your phone, we need your permission to leave certain types of information on your answering machine, or via voice mail. Please indicate your preference by checking one or more of the boxes below.

☐ Do not leave any medical information on an answering machine or voice mail.

☐ I give permission to _____ personnel to leave the following forms of information pertaining to me on my home answering machine or voice mail at the number(s) listed below.

Phone Number (Home) _____ (Work)_____

Appointment Reminders	_____Yes	_____No
Test Results	_____Yes	_____No
Other _____	_____Yes	_____No
Any Type of Medical Communication	_____Yes	_____No

I assume responsibility to inform the practice of changes in my phone number(s) or my preference.

Name _____

*Signature*_____ *Date* _____