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PATIENT CONTACT CONSENT FOR PROTECTED HEALTH INFORMATION

*** YOU HAVE THE RIGHT TO REVOKE ANY INFORMATION BY COMPLETING A NEW FORM ***

DOCTOR TO PATIENT COMMUNICATION

When necessary, how do you prefer to be notified of Pathology, Laboratory, other test results, or answers to your questions?

- ○ Speak only to you personally? **YES** **NO**
- ○ May we speak with another member of your household? **YES** **NO**

If so, who? Name: _____ Relationship: _____

Your phone numbers:

Primary #: _____ May we leave a message? **YES** **NO**

Alternative #1:_____ May we leave a message? **YES** **NO**

Alternative #2:_____ May we leave a message? **YES** **NO**

If leaving a message regarding your results, your voice mail or answering machine greeting must be identifiable by name or number.

FAMILY TO DOCTOR COMMUNICATION

At times, a spouse, parent(s), children, and significant others wish to contact our doctors or staff with questions about diagnosis, treatment plans, medications, test results, emergencies, etc. Is there a person with whom we may discuss your personal health information?

- ○ **NO**, do not discuss my personal health information with anyone.
- ○ **YES**, you may discuss my personal health information with the following person(s):

Name of Person: _____ Relationship: _____

Name of Person: _____ Relationship: _____

Print Name of Patient: _____

Signature of Patient: _____Date: _____

Reviewed, no changes made. Parent or Legal Guardian Initials: _____ Date: _____
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