Preferred Communication

Patient Name: ________________________ **Date**: ______________

The HIPPA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time.**

Best form of contact:

Home Phone: ________________________

O Yes, I give you permission to leave a message with detailed information

O Leave Message with call back number only

Cell Phone: ___________________________

O Yes, I give you permission to leave a message with detailed information

O Leave Message with call back number only

Work Phone: ___________________________

O Yes, I give you permission to leave a message with detailed information

O Leave Message with call back number only

Email Address: ___________________________

O Yes, I give you permission to leave a message with detailed information

O Leave Message with call back number only

Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help with your payment issues. You may use this form to name specific individuals who you want us to share you information with; this may include information about your general medical condition and diagnosis (such as treatment and payment options), access to dental records, prescription pick-up and scheduling appointments.

Important Note: we may share your information as set forth in our Notice of Privacy Practices to other person not names on this form as needed for your care or treatment or the payment of services we have provided.

Please indicate the person(s) you prefer we share your information with below:

Name: ________________________ **Telephone:** ______________________ **Relationship:**_______________________

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Name: ________________________ **Telephone:** ______________________ **Relationship:**_______________________

Name: ________________________ **Telephone:** ______________________ **Relationship:**_______________________

Patient Signature: ______________________________