WILLIS-KNIGHTON HEALTH SYSTEM

Alternative Contact/Preferred Method of Communication Form

Patient Name_____ Date of Birth_____

We at WKB Family Medicine Associates take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____ I do NOT authorize anyone to receive information regarding my medical care.

_____ I authorize my physician and the employee of this clinic to speak with:

1. Person:_____ Relationship:_____
   Phone number(s): _____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

2. Person:_____ Relationship:_____
   Phone number(s): _____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

3. Person:_____ Relationship:_____
   Phone number(s): _____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

Please check your primary and secondary preferred methods of communication:

_____ Home Phone/Answering Machine _____ Mail _____ Work Phone

_____ Cell Phone (voice mail) _____ Cell Phone (text message)

_____ Email and email address _____

Electronic Communication is my preferred method ☐ yes ☐ no

(In order to electronically communicate to you or anyone you designate, we are required to have your written permission).

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form.

Any problems and/or questions concerning this form are to be referred to the Willis−Knighton Health Systems Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

PATIENT SIGNATURE:_____

PARENT/GUARDIAN SIGNATURE: _____

WITNESS SIGNATURE: _____

DATE:_____ TIME:_____