

Alternative Contact/Preferred Method of Communication Form

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: Person: Relationship: Phone number(s): Relationship: Appointments Account/Bill Lab Results Test Results Medical Care Treatment Person: Relationship: Phone number(s): Relationship: Phone number(s): Relationship: Phone number(s): Phone number(s): Relationship: Phone number(s): Cell Phone number(s): Relationship: Phone number(s): Relationship: Phone number(s): Cell Phone number(s): Relationship: Phone number(s): Relationship: Phone number(s): Cell Phone number(s): Relationship: Phone number(s): Relationship: Phone number(s): Relationship:	Patient Name	Date of Birth	
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:			
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:	very seriously. We will not and cannot release information without your written authorization.		
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Phone number(s):	Appointments Account/Bill	Lab Results Test Results Medical Care Treatment	
Phone number(s):	2. Person:	Relationship:	
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:			
Phone number(s):	Appointments Account/Bill	Lab Results Test Results Medical Care Treatment	
Phone number(s):	3. Person:	Relationship:	
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:	Appointments Account/Bill	Lab Results Test Results Medical Care Treatment	
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.	Please check your primary and secondary preferred methods of communication:		
Email and email address Electronic Communication is my preferred method ges 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:			
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	PATIENT SIGNATURE:		
WITNESS SIGNATURE:			