

Patient Name: _____ DOB: _____

I wish to be contacted in the following manner (check all that apply):

Oral communication:

- | | |
|---|---|
| <input type="checkbox"/> Home telephone # _____ | <input type="checkbox"/> Work telephone # _____ |
| <input type="checkbox"/> O.K. to leave message with detailed information. | <input type="checkbox"/> O.K. to leave message with detailed information. |
| <input type="checkbox"/> Leave message with call-back number only. | <input type="checkbox"/> Leave message with call-back number only. |
| <input type="checkbox"/> O.K. to communicate using email _____ | |
| <input type="checkbox"/> Other: _____ | |

Written communication:

- | | |
|---|--|
| <input type="checkbox"/> O.K. to mail to my home address. | <input type="checkbox"/> O.K. to fax to this # _____ |
| <input type="checkbox"/> O.K. to mail to work/office address. | <input type="checkbox"/> Other: _____ |
-

I permit the Agency to discuss my PHI (personal health information) with, and to disclose my PHI to, the following individuals.

- Spouse _____
- Adult Children _____
- My parent(s) _____
- Personal representative _____
-

If checked, the following additional instructions apply:

Patient signature

Date

If signed by patient's authorized representative, describe the representative's authority:

- Patient is a minor; I am the patient's parent and natural guardian.
- Patient is a minor; I am the patient's guardian, appointed by the _____ County Juvenile Court.
- Patient is a ward; I am the patient's guardian, appointed by the _____ County Juvenile Court.
- The patient is deceased. I am the patient's surviving spouse.
- The patient is deceased. I am the executor or administrator of the patient's estate, appointed by the _____ County Probate Court.
- I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for Health Care.
- Other (describe): _____