# Patient Communication Form

From time to time in caring for our patients it may become necessary to contact you. Often our patients are not available when we all them and we would like to be able to leave detailed telephone messages (i.e. lab results) when possible. There are also times where you may want us to communicate labs, medications, treatment plans, or billing information to a trusted family member or friend. In order to protect your privacy we need your written permission to leave detailed messages on your answering machine, voicemail or with a trusted family member or friend.

☐ I DO CONSENT

I $(patient.name) consent for my healthcare provider to leave detailed message regarding my personal health information (PHI) using the following options: (Provide information below) **Please note this consent will remain in effect until you rescind in writing.**

**HOME PHONE NUMBER**

**MY CELL PHONE NUMBER**

**MY WORK PHONE NUMBER**

**NAME OF FAMILY OR FRIEND AND PHONE NUMBER**

Please state relationship to patient

**NAME OF FAMILY OR FRIEND AND PHONE NUMBER**

Please state relationship to patient

**I DO NOT CONSENT**

☐ For my provider to leave detailed telephone messages regarding my personal health information (PHI)

☐ For my provider to communicate messages regarding my personal health information (PHI) to family members.

**REVOCATION OF PRIOR CONSENT**

☐ I wish to rescind or stop any prior consent to leave detailed messages.

☐ I wish to rescind or stop any prior consent for my provider to communicate messages regarding my personal health information (PHI) to family members.

**PATIENT AND/OR PATIENT'S REPRESENTATIVE SIGNATURE**

03/03/2022