ON DEMAND

Patient's Name: _____
DOB: _____
TODAY'S DATE: _____

PROTECTED HEALTH INFORMATION PATIENT PREFRENCES

Please help us accommodate your wishes regarding how we communicate with you about your health care by completing and signing this form.

☐ Yes ☐ No May we use your first name, last name or both to identify you in the waiting room?

If not, how would you prefer to be identified? _____

☐ Yes ☐ No May we leave a message on your answering machine or voicemail reminding you of an appointment, or requesting that you call our office? If not, is there an alternate method of contacting you by phone?

Number: _____ ☐ Portal ☐ Cell ☐ Other

☐ Yes ☐ No May we leave information regarding an upcoming appointment or a request for you to call us with another individual in your household?

☐ Yes ☐ No May we send written correspondence in a sealed envelope to you home address? If not, is there an alternative address where we may send confidential communication to?

_____

☐ Yes ☐ No Is there another person with whom you give permission for us to speak with about your health care? If yes, please list name(s) and relationship:

_____

_____

_____

Please list any physicians you would like copies of office notes and test results sent to:

_____

_____

_____

_____

_____ _____

Signature of Patient or Legal Guardian Date