**Patient Communication Authorization**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We must call on occasion to discuss confidential, protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

Mobile Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Can we text your mobile phone about appointments

e.g., appointment reminders, changes made to your appointment time, etc.? Yes ❑ No ❑

* Can we text your mobile phone about the account

e.g., unpaid statements, balance due, etc. Yes ❑ No ❑

* Can we call this number and leave a message concerning your health? Yes ❑ No ❑

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Can we email you about appointments,

e.g., appointment reminders, changes made to your appointment time, etc.? Yes ❑ No ❑

* Can we email you about the account

e.g., unpaid statements, balance due, etc. Yes ❑ No ❑

* Can we email you with information concerning your health? Yes ❑ No ❑

Home Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Can we call this number and leave a message concerning your health? Yes ❑ No ❑

Work Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Can we call this number and leave a message concerning your health? Yes ❑ No ❑

❑ I give permission to the individual(s) listed below to receive protected health information:

❑ You may also call these individuals on my behalf at the phone number(s) listed below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* This authorization can be revoked or modified by notifying us IN WRITING at any time.

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Patient’s Signature Date