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 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 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:

_____

_____

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

_____ _____
Patient's Signature Date