Medical Information Communication Preferences

Patient _____ MR#_____ DOB ____/___/____

As our patient, we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential medical information, such as test or lab results, to you and/or others involved in your care. Please note that "appointment reminder telephone calls" may be left at the contact number(s) you list below. Please list your email address to receive online health care educational programs ordered by your care provider.

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

☐ I **give permission** to leave medical information pertaining to me, my dependent or child, at the numbers listed below:

Method	Yes	No	Area code, Phone#, EMAIL
Home telephone			
Answering Machine			
Work phone			
Cell phone			
Email for patient portal secure email registration			
Email to receive provider ordered online patient education handout			

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

☐ **Do not release medical information** to anyone other than myself.

☐ **I give permission to release medical information** pertaining to me to the individuals listed below:

Name	Relationship (i.e, spouse, parent, son, daughter, etc.)	Area code, Phone #
Comments:		

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

_____ _____

Signature of Patient or Patient's Legal representative

_____ _____

Please Print Name Date & Time