Patient Communication Consent

PLEASE PRINT

I, ____ ________________

(Name of Patient or Guardian) (Date of Birth)

hereby request AMITA Health to keep communication regarding my health information confidential by adhering to the following communication requests:

You may contact me at:

Home Phone Number: ________________________________

Work Phone Number: ________________________________Extension___________

Cell Phone Number: ________________________________ ☐ You may communicate with me via text message.

Email: ____

☐ Do not contact me via phone. I will be responsible for communicating with the clinic.

If I am not available at the time of your call: ***You may leave a message and medical information on my answering machine or voicemail:***

Home: ☐ Yes ☐ No
Work: ☐ Yes ☐ No
Cell: ☐ Yes ☐ No

☐ Do not leave medical information on my answering machine or voicemail.

You may also leave a message and discuss medical information with the following person(s):

Name:___________________________ Relationship:____________ Phone:_____________________

Name:___________________________ Relationship:____________ Phone:_____________________

☐ Only leave medical information with me, the patient, or guardian.

IN CASE OF EMERGENCIES ONLY, PLEASE CONTACT:

Name: ______________________ Relationship: ______________ Phone: (____) _______-________

Signature: ____ Date: ______/______/________