Request to Receive Confidential Communication of Protected Health Information

Patient Name: ______________________________ Date of Birth: _______________

Appointment Confirmations:

____ Yes ____No E-mail confirmation

E-Mail Address: ____________________________________

____ Yes ____ No Text Messages

Cell phone: ____

*Must be primary contact number to receive

All other Medical/Billing Information:

____ Yes No ____ Contact me at home phone: _____________________________

____ Yes No ____ Contact me on my cell phone: ___________________________

____ Yes No ____ Contact me on my work phone: __________________________

Okay to leave a message regarding detailed medical information including, but not limited to, test results? ____ Yes No ____

Leave only a request for me to call back. ____ Yes No ____

Signature: ____

Relationship to Patient: ____________________________

Date: ____________________

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