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PATIENT PRIVACY METHOD OF CONTACT INFORMATION

Patient Name:_____ **DOB:**___/___/___ **Age:**___ **Account #:**_____

Home Phone:_____ **Mobile Phone:**_____

Email:_____

You may contact me or my legal guardian in the following manner:

I have indicated in numeric order my preferences with a 1 as my preferred method of contact, followed by a 2 and 3.

Appointment Information		**Medical Information**	
Home Phone (Include Auto Call)	_____	Home Phone (Include Auto Call)	_____
Mobile Phone (Include Auto Call)	_____	Mobile Phone (Include Auto Call)	_____
Mobile Text (Auto Text)	_____	Mobile Text (Auto Text)	_____
Send via Mail	_____	Send via Mail	_____
Send via Patient Portal/Email	_____	Send via Patient Portal **(must have portal)**	_____

Listed below are the individual(s) you may communicate with regarding my health care. This is other than/in addition to those parent(s) or legal guardian(s) who have signed this authorization below.

1) **Name:**_____ **Relationship to Patient:**_____

Emergency Phone Number:_____ **Please Specify: ___Home ___Mobile**

2) **Name:**_____ **Relationship to Patient:**_____

Emergency Phone Number:_____ **Please Specify: ___Home ___Mobile**

Patient/Legal Representative Signature:_____ **Date:**_____

Printed Name if Above is a Legal Representative:_____

Relationship to the Patient:_____

Expiration Date of Consent: Until Rescinded