PATIENT CONTACT PREFERENCE

Patient Name: ___________________________ DOB: ______________

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of health information (PHI). The individual is also provided the right to request confidential communication or that a communication of HI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

□ Home Telephone ______________________ or Cell ___________________
○ OK to leave message with detailed information regarding my child. ○ OK to leave message with call back number only.

□ Written Communication
○ OK to mail to my home address.
○ OK to mail to my work/office.
○ OK to fax to this number ____________________

□ Work telephone _______________________ ○
OK to leave a message with detailed information ○
Leave message with call back number only.

□ Text Messages **(at this time we are not using this method but may in the future)** ○ OK to leave a detailed text message regarding my child.

□ Email Messages **(at this time we are not using this method but many in the future)** ○ Ok to send email with detailed message regarding my child.
Email Address: ____

____ ____________________
Patient / Parent / Guardian Signature Date

____ ____________________
Print Name Relationship to Patient

Note: Please notify our office should any of the above communication information change. Thank you