



Communication Agreement

Patient Name _____ Date of Birth _____

Your Healthcare Provider may need to contact you to discuss your health, review results of testing or to coordinate your care. Please review and answer a few questions regarding your preferences regarding this communication. Additional phone numbers can be listed below.

- 1. May we leave messages regarding your health information on your answering machine or voicemail at home?
2. May we discuss your medical care with anyone that answers the telephone at your home?
3. May we leave messages regarding your health information on your answering machine or voicemail at work?
4. May we leave messages regarding you health information on your cellular telephone voicemail?
5. Are there any members of your family, household or those coming with you to this appointment with which we should not discuss any of your health care issues?

Explain: _____

I AGREE that I am making this request for my convenience, without coercion or pressure by my healthcare provider or any other party. I understand that this request may result in someone other than me learning of my personal health information. I also understand that this agreement will be in place until I personally request in writing that it be cancelled. I will be responsible for completing a new request form to update contact numbers should they change. If my contact numbers should change, I give permission to send test results to me by mail.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship (parent of legal representative)

Please provide phone numbers below if applicable:

HOME: _____

WORK: _____

CELL: _____

ADDITIONAL: _____