



PHONE COMMUNICATION PREFERENCE FORM

Please help us contact you, **especially when your labs/studies are ABNORMAL!**

Is your voice mail box on your mobile phone set up & not full?

(Please circle your preferences below)

Preferred Cell phone number _____

OK to call cell? **NO YES**

If "Yes," OK to leave detailed message including results? **NO YES**

Preferred Home phone number _____

OK to call home? **NO YES**

If "Yes," OK to leave detailed message including results? **NO YES**

Preferred Work phone number _____

OK to call work? **NO YES**

If "Yes," OK to leave detailed message including results? **NO YES**

I give permission to disclose my health information to the individuals below:

Name: _____

All information

Relation: Spouse POA other: _____

Messages only to call back

Name: _____

All information

Relation: Spouse POA other: _____

Messages only to call back

Please Note: If your spouse or significant other is not listed above, information will not be disclosed to him/her.

This form does **NOT** grant the people named on it the right to obtain access to or copies of your health records

E-mail Address: _____

By providing my email address I understand I will *remain/be enrolled in a patient portal account*. This service is offered to adult patients 18 years of age and older.

Check this box if you do **NOT** want to be enrolled in the patient portal.

Patient Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____