Contemporary Women's Care

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PATIENT COMMUNICATION PREFERENCES

I wish to be contacted in the following manner(s) pertaining to my healthcare:

Home Telephone: _____

_____ OK to leave a detailed message

_____ Leave message with a call back number only

Mobile/Cell Phone: _____

_____ OK to leave a detailed message

_____ Leave message with a call back number only

Work Telephone: _____

_____ OK to leave a detailed message

_____ Leave message with a call back number only

Mailing Address:

_____

_____

WHO TO CONTACT: I hereby give Contemporary Women's Care, P.A. permission to disclose and discuss any information related to my medical care to the following individuals:

Name: _____ Relationship: _____ Number:_____

Name: _____ Relationship: _____ Number:_____

Name: _____ Relationship: _____ Number:_____

_____ I do not wish to give permission to other individuals to have access to any information regarding my medical condition or treatment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information not listed above or approved under the HIPAA Privacy Act, will require specific authorization prior to disclosure of any information.

Name of Patient or Legal representative: _____

Signature of Patient or Legal representative: _____ Date: _____