CONFIDENTIAL COMMUNICATION

Patient Name _____ Date of Birth _____

Please provide preferred method of communication

I hereby request the following means of communication related to my personal health, treatment, diagnosis, test results or billing as noted below:

I prefer to be contacted by (circle): Home Phone Y / N Cell Phone Y / N Work Phone Y / N US Mail Y / N

I give permission for messages to be left on my voicemail: ❑ Yes ❑ No

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

3. Name: _____ Relationship: _____ Phone: _____

HIPAA AUTHORIZATION TO DISCLOSE

I give my permission to disclose my personal health information, treatment, diagnosis, test results or billing with:

❑ Check here if you choose the same person(s) as your emergency contact. Please sign and skip to the next section.

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

3. Name: _____ Relationship: _____ Phone: _____

Patient Signature _____ Printed Name _____ Date _____

DISCLAIMER

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to CFD. I understand that a revocation is not effective to the extent that CFD has relied on the use or disclosure of the protected health information.