Consent to Communicate Form

Patient:_____

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

Please mark the ways that you consent to us communicating with you:

Method	**Ok to Leave Voicemail**		**Ok to Leave Message with Another Person**		**Preferred Contact Method(s)**	**Best Time to Call***
Call Work Phone	Yes ___	No ___	Yes ___	No ___		
Call Cell Phone	Yes ___	No ___	Yes ___	No ___		
Call Home Phone	Yes ___	No ___	Yes ___	No ___		
Send Email	Yes ___	No ___				
Email Appointment Reminders	Yes ___	No ___				
Email Office Specials	Yes ___	No ___				
Email Medical Info	Yes ___	No ___				
Send Regular Mail	Yes ___	No ___				
Mail to which Address: Home ____ Other ____ (please list):						
Send Text Message - **if yes, please list carrier** (e.g., AT&T):	Yes ___	No ___				
Text Appointment Reminders	Yes ___	No ___				
Text Office Specials	Yes ___	No ___				

* Best Time to Call:? Morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message.