Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home #_____

Work #_____

Mobile #_____

Other _____

E-Mail Communication Preferences

Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs.

By providing the information above I agree that Maple Lawn Surgery Center, LLC or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, Maple Lawn Surgery Center, LLC or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Maple Lawn Surgery Center, LLC when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? (If no, please provide an alternate mailing address below.)

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name	Telephone
____ Spouse	_____	_____
____ Caretaker	_____	_____
____ Child	_____	_____
____ Parent	_____	_____
____ Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been give the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature Date

_____ _____

Printed Name Relationship to Patient