HEALTH CHOICE CLINIC

COMMUNICATING WITH PATIENT

In order to effectively communicate with you regarding your medical information, we request that you complete this form to indicate the best way(s) to provide your confidential information such as lab results, responding to message you left for your provider's office, or prescription information. Information may be delivered via phone, secure email, mail, and/or leaving messages on your voicemail.

Please check the boxes that you grant permission for Health choice clinic to use for communication with you.

☐ You may contact me by telephone	Phone number: _____
☐ You may leave a message/voicemail	Phone number: _____
☐ You may contact me via message/voicemail	
☐ You may contact me via Email	

Do you grant us permission to communicate with anyone else: YES NO

If yes, please list name(s):

Name/phone number	Relationship	Options
		☐ Appointment Information ☐ Billing Information ☐ Medical/Health Information
		☐ Appointment Information ☐ Billing Information ☐ Medical/Health Information
		☐ Appointment Information ☐ Billing Information ☐ Medical/Health Information

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_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party Relationship