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Confidential Communication Preference

Patient Name: _____ Date of Birth: _____

You may request to receive confidential communications of Protected Health Information in the method you prefer or at any alternate address. You may also authorize that your Protected Health Information (PHI) be released to individual(s) other than yourself. Please select all that apply.

I authorize Dr. Roger Washington and his entire staff to leave messages at the following:

DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN CALL.

- Yes No Leave message on answering machine or voicemail
- Yes No Home Phone _____
- Yes No Work Phone _____
- Yes No Cell Phone _____
- Yes No Alternate Phone _____

Other Person(s) authorized to receive Protected Health Information (PHI) on my behalf:

Name: _____ All
 Phone Number: _____ All **excluding** mental/ sexual health
 Relationship: _____ Test results only (Xray, labs, etc.)

Name: _____ All
 Phone Number: _____ All **excluding** mental/ sexual health
 Relationship: _____ Test results only (Xray, labs, etc.)

All changes to this document must be submitted in writing.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____