Patient Confidential Communication Preferences

Patient Name: _____

The purpose of this form is so we can contact you or individuals you designate to discuss any health information that requires immediate communication. If acceptable to you, list individuals that you authorize for Cardiology Wellness Center to contact, if an urgent issue should arise that requires immediate contact (for example, family members, friends, caregivers). Examples of the type of information we may need to communicate are: test results, lab results, prescription information, and messages from your doctor.

PLEASE DO NOT LIST OTHER PHYSICIANS. We communicate with them as part of your treatment.

If you do not want us to talk to anyone other than yourself, please indicate that below. We are happy to respect your wishes.

☐ **Do not discuss my PHI (protected health information) with anyone other than myself**

☐ **It is acceptable to discuss my PHI (protected health information) with the following person(s):**

Name	Telephone Contact

☐ **It is acceptable to leave a message:**
- ☐ **with the person(s) listed above,**
- ☐ **on my answering machine at home,**
- ☐ **on my voice mail at work.**

☐ **NEVER LEAVE A MESSAGE**

☐ **It is acceptable to:**
- ☐ **Call my workplace.**
- ☐ **Never call my workplace.**

Patient Signature: _____

Updated: Please initial and date if no changes

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