

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Preferences for Contact & Release of Information Regarding Test Results**

We feel it is very important to keep you informed and educated about your test results and other health information as we work as your partners in your care. However, we also strive to protect the privacy of your health information.

Please indicate how you would like to be contacted by our physicians and staff. We will follow the guidelines you set forth here, unless otherwise advised.

Please be sure to update this information as needed, for phone number changes or changes in preferences.

HOME PHONE NUMBER: \_\_\_\_\_

- Use this number first
- Ok to leave a detailed message or
- Leave call-back number only

CELL PHONE NUMBER: \_\_\_\_\_

- Use this number first
- Ok to leave a detailed message
- Leave call-back number only

WORK PHONE NUMBER :

- Use this number first
- Ok to leave a detailed message
- Leave call-back number only

If you would like us to waive your protected rights and provide messages, information, or results to a spouse, significant other, or family member, please indicate below. My protected health information may be shared with the following persons:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient (or Guardian) Signature: \_\_\_\_\_