Medical Information Communication Preferences

Patient ________________________________ MR#________________________ DOB ____/___/____

The information on this form will be utilized for all LVPG practices, LVHN clinics and outpatient departments, excluding behavioral health services.

As our patient, your care team is a partner in your healthcare. From time to time we may need to contact you about your care or treatment plan when you are not in the office/practice. To maintain your privacy and our partnership, please indicate your preferred method for us to communicate confidential medical information, such as test or lab results, to you and/or to others involved in your care. Appointment reminder telephone calls or texts may be left at the telephone or cell phone number(s) you list below. Your responses and feedback about your healthcare experiences are important to us so that we can meet your expectations and continually improve as your healthcare partner. You may receive a survey by email, telephone or text to give us this feedback. If you choose not to receive a survey, you can decline at any time by replying to the survey request with an "opt out or decline" preference. Thank you.

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

☐ I give permission to **leave medical information** pertaining to **me, my dependent or child**, at the numbers listed below:

Home Phone__________________________
____ OK to leave message with details
____ Leave call back number only

Mobile Phone ____________________________
____ OK to leave message with details
____ Leave call back number only

Work Phone__________________________
____ OK to leave message with details
____ Leave call back number only

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases, you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

☐ I give **permission to release medical information** pertaining to me to the individuals listed below.

Name	Relationship (i.e. spouse, parent, son, daughter, etc.)	Area Code, Phone # - Extension

☐ ***Do not release medical information to anyone other than myself.***

I assume responsibility to inform the office/practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

____ ____________________
Signature of Patient or Patient's Legal Representative Date

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Please Print Signer's Name