NAME OF PATIENT:	DOB:

Communications Preferences

From time to time, it may be necessary and/or desirable to contact you regarding your care. Please complete the following to indicate your preferences for communicating with you.

I wish to be contacted in the following manner:
(ONLY COMPLETE THE OPTIONS THAT APPLY TO YOU)

Home Phone: _____ May we leave a detailed message? Yes No

Cell Phone: _____ May we leave a detailed message? Yes No

Work Phone: _____ May we call you at work? Yes No
May we leave a detailed message? Yes No

Other Phone (please specify): _____ May we leave a detailed message? Yes No

Other (please be specific):_____

May we speak with someone else regarding your medical care, such as your primary care provider or a family member? Yes No
If so, please list their name and their relationship to you.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Currently, we will contact you by phone to remind you of upcoming appointments. Additionally, we will send health maintenance reminders by mail and you will be notified of your test results by phone or by mail, depending on the nature of your tests. If you choose to be contacted by another method or no notification at all, please use this area to let us know your preferences.

_____

_____

_____

I understand that this request is only applicable to information held by Specialists in Women's Care, PC. I also understand that the use of an alternative means of communication may not be protected and could endanger my privacy. I understand that I may change this consent, in writing, at any time. By signing this form, I am consenting to the use and disclosure of my protected health information by Specialists in Women's Care, PC.

_____ _____

Signature of patient, parent or legal guardian Date