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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: ______________________________
Phone Number: ________________________
Relationship: __________________________

☐ All
☐ All **excluding** mental/ sexual health
☐ Test results only (Xray, labs, etc.)

Name: ______________________________
Phone Number: ________________________
Relationship: __________________________

☐ All
☐ All **excluding** mental/ sexual health
☐ Test results only (Xray, labs, etc.)

All changes to this document must be submitted in writing.

Patient Signature: ______________________________ **Date:** ______________

Witness Signature: ______________________________ **Date:** ______________