PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE PREFERENCES

Patient Name:____________________________________ DOB:______/______/______
Month Day Year

Authorized Methods of Communication

(√ Check all that apply AND please * asterisk your preferred/first choice method of communication)

☐ *Residence Telephone*	☐ *Work Telephone*	☐ *Cell Phone*
Number: ( )	Number: ( )	Number: ( )
☐ Leave call-back number only: do not leave message	☐ Leave call-back number only: do not leave message	☐ Leave call-back number only: do not leave message
☐ OK to leave detailed message with person	☐ OK to leave detailed message with operator	
☐ OK to leave detailed message on answering machine	☐ OK to leave detailed message on personal voice mail	☐ OK to leave detailed message on personal voice mail

☐ *Written Correspondence:*

☐ Mail/delivery service
Address:

☐ Fax: ( )

☐ *Other*: EMAIL

Patient Signature: ____________________________________ Date: ________________