PATIENT'S PREFERENCES REGARDING THEIR PROTECTED HEALTH INFORMATION

Telephone Communication Preferences

Location	May we call you here?		May we leave a message?	
Home	☐ Yes	☐ No	☐ Yes	☐ No
Work	☐ Yes	☐ No	☐ Yes	☐ No
Mobile Phone	☐ Yes	☐ No	☐ Yes	☐ No
Other_____________________	☐ Yes	☐ No	☐ Yes	☐ No

Mail Communication Preferences

May we send mail to your home address? ☐ Yes ☐ No
(If no, please provide an alternate mailing address below.)

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Other than you, your insurance company, and health care providers involved in your care, whom may we talk with about your health care information? (Check all that apply)

	Name	Telephone
☐ Spouse	____________________________	____________________
☐ Caretaker	____________________________	____________________
☐ Child	____________________________	____________________
☐ Parent	____________________________	____________________
☐ Other	____________________________	____________________

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

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I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

___________________________________ ______________________
Patient or Legal Representative Signature Date

___________________________________ ______________________
Printed Name Relationship if NOT Patient

COAST SURGERY CENTER