

## Patient Preference Regarding Communication of Health Information

### Who to Contact

I hereby give permission to ***Baylor Family Medical Center at Riverside*** to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s) and/or close personal friend(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

### How to Contact

What is your preferred method of communication with the clinic?

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of communication, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

#### First Method of Communication

Please tell us your preferred method of communication by checking the appropriate box and providing your contact information below.

- |                                     |                                       |  |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Pager        | <input type="checkbox"/> Durable Power of Attorney |
| <input type="checkbox"/> Work Phone | <input type="checkbox"/> Fax          | <input type="checkbox"/> Other                     |
| <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Letter       |  |
| <input type="checkbox"/> E-mail     | <input type="checkbox"/> Nursing Home |  |

**Please print clearly:**

Patient Name: \_\_\_\_\_ Patient Identifier #: \_\_\_\_\_

If above method of communication is by phone, please check the appropriate box:

- OK to leave a message with detailed information.  
 Leave a message with call-back number only.

Second Method of Communication

Please tell us an alternative method of communication by checking the appropriate box and providing your contact information below. We will use the alternative method of communication if we cannot reach you using your preferred method of communication.

- |                                     |                                       |  |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Pager        | <input type="checkbox"/> Durable Power of Attorney |
| <input type="checkbox"/> Work Phone | <input type="checkbox"/> Fax          | <input type="checkbox"/> Other                     |
| <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Letter       |  |
| <input type="checkbox"/> E-mail     | <input type="checkbox"/> Nursing Home |  |

**Please print clearly:**

If the above method of communication is by phone, please check the appropriate box:

- OK to leave a message with detailed information.  
 Leave a message with call-back number only.

In-Clinic Communication Only

I request that communication regarding my medical condition(s) to occur **only** when I am in the clinic. Please print and hand me information when I am in the clinic. Do not call, mail, or otherwise communicate with me regarding my medical condition(s).

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require my specific authorization prior to the disclosure of any medical information.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Legal Representative

\_\_\_\_\_  
Relationship to Patient