



Patient Communication Preferences Regarding PHI

Telephone Communication Preferences:

Home Phone _____

Work Phone _____

Mobile Phone _____

Other _____

Place Patient Identification Label Here

Email Communication Preferences:

Email Address _____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Surgery Center of Gilbert or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service, or leave a voice message on an answering device. If an email address has been provided, the Surgery Center or one of its legal agents may contact me with an email notification regarding my care, surgery center services or my financial obligation.

Mail Communication Preferences

May we send mail to your home address? If no, please print an alternative mailing address:

Other than you, your insurance company and health care providers involved in your care, who can we talk with about your health care information? Check all that apply;

Table with 2 columns: Name, Telephone. Rows include Spouse, Caretaker, Child, Parent, Other.

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 Personal Representative Signature

Date

Printed Name

Relationship to Patient