

PLEASE PRINT

I, _____
(Name of Patient or Guardian) _____
(Date of Birth)

hereby request AMITA Health to keep communication regarding my health information confidential by adhering to the following communication requests:

You may contact me at:

Home Phone Number: _____

Work Phone Number: _____ Extension _____

Cell Phone Number: _____ ☐ You may communicate with me via text message.

Email: _____

☐ Do not contact me via phone. I will be responsible for communicating with the clinic.

If I am not available at the time of your call: *You may leave a message and medical information on my answering machine or voicemail:*

Home: ☐ Yes ☐ No

Work: ☐ Yes ☐ No

Cell: ☐ Yes ☐ No

☐ Do not leave medical information on my answering machine or voicemail.

You may also leave a message and discuss medical information with the following person(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ Only leave medical information with me, the patient, or guardian.

IN CASE OF EMERGENCIES ONLY, PLEASE CONTACT:

Name: _____ Relationship: _____ Phone: (____) _____ - _____

Signature: _____ Date: ____/____/____