Integrative Rheumatology

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PATIENT COMMUNICATION CONSENT

From time to time in caring for our patients it may become necessary to contact you. Often our patients are not available when we all them and we would like to be able to leave detailed telephone messages (i.e. lab results) when possible. There are also times where you may want us to communicate labs, medications, treatment plans, or billing information to a trusted family member or friend. In order to protect your privacy we need your written permission to leave detailed messages on your answering machine, voicemail or with a trusted family member or friend.

Patient Name _____ **Date of Birth** _____

I ❑ **DO** ❑ **DO NOT** consent for my healthcare provider to leave a detailed message regarding my personal health information (PHI) using the below options. ***Please note this consent will remain in effect until you rescind in writing.***

Home Phone Number _____

Cell Phone Number _____

Work Phone Number _____

❑ I **DO NOT** consent for my provider to communicate any messages regarding my personal health information (PHI) to family members.

❑ I **DO** consent for my provider to share my personal health information (PHI) with the following family members.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

REVOCATION OF PRIOR CONSENT

❑ I wish to rescind or stop any prior consent to leave detailed messages.

❑ I wish to rescind or stop any prior consent for my provider to communicate messages regarding my personal health information (PHI) to family members.

_____ _____

Patient and/or Patient's Representative Signature *Date*