Communication Preferences and Message Agreement for Personalize Healthcare of Tucson:

Patient Request to Receive Confidential Communications by Alternative Means

Patient Name: _____ DOB_____

The ability to communicate with our patients is important to their health. Further, the HIPAA regulations give patients the right to request that health care providers communicate with them through alternative methods of communications or locations. To facilitate your rights, and to ensure we can contact you to communicate appointments, treatments, billing or other important information that may contain your protected health information, please complete this form to define your communication and message preferences.

Please circle "yes" or "No" to the following questions and include the requested numbers or information as appropriate to let us know how you wish "OUR ORGANIZATION" to communicate with you.

Yes **No** 1. You may call my home phone (____-_____-_____) and leave a message.

Yes **No** 2. You may leave a message with anyone answering my home phone (___-____-_____).

Yes **No** 3. You may leave a voice message on my cell phone (____-_____-_____).

Yes **No** 4. You may send text messages to me at (____-_____-_____).

Yes **No** 5. You may leave a voice message on my work voice mail (____-_____-_____).

Yes **No** 6. You may communicate with me via my email address _____

Yes **No** 7. Direct written communications to my home address (as provided) If No, please define address below: __Other Residence __Work __Other

_____

_____

Other Special Communication Directives & List the names of people that we may release the above information to:

_____

_____

I hereby release and hold harmless "Personalized Healthcare of Tucson", its staff or agents, from any liability that may arise from the release of information as authorized above. I understand it is my responsibility to notify "Personalized Healthcare of Tucson" in writing of any changes in the preferences I have indicated above. I understand that I may revoke this consent in writing at any time and that the consent will remain enforce unless otherwise revoked in writing. I understand this form is valid one year from the date it is signed.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Signature of "Our Organization's" Employee receiving this form Date