Print Form

PATIENT CONTACT INFORMATION

The HIPAA privacy rule provides the patient with the right to request confidential communications or that a communication of Protected Health Information (PHI) be made by alternative means, such as sending correspondence to the individual's office instead of to the individual's home

I wish to be contacted in the following manner (check ALL that apply):

☐ Home telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only.

☐ Cell Phone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only.

☐ Work telephone _____
- ☐ OK to leave message with detailed information.
- ☐ Leave message with call-back number only.

☐ Written communication
- ☐ OK to mail to home address _____
- ☐ OK to mail to my work/office address _____
- ☐ OK to FAX to this number _____
- ☐ OK to email to this address _____

☐ Other
- ☐ OK to share information with the following person(s):

_____

_____

_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

Mallory Osteopathic family practice