

PATIENT'S PREFERENCES REGARDING THEIR PROTECTED HEALTH INFORMATION

Telephone Communication Preferences

| <u>Location</u> | <u>May we call you here?</u> | | <u>May we leave a message?</u> | |
|------------------------|-------------------------------------|-----------------------------|---------------------------------------|-----------------------------|
| Home | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Work | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mobile Phone | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Mail Communication Preferences

May we send mail to your home address? Yes No
(If no, please provide an alternate mailing address below.)

Other than you, your insurance company, and health care providers involved in your care, whom may we talk with about your health care information? (Check all that apply)

| | Name | Telephone |
|------------------------------------|-------------|------------------|
| <input type="checkbox"/> Spouse | _____ | _____ |
| <input type="checkbox"/> Caretaker | _____ | _____ |
| <input type="checkbox"/> Child | _____ | _____ |
| <input type="checkbox"/> Parent | _____ | _____ |
| <input type="checkbox"/> Other | _____ | _____ |

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

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 Legal Representative Signature

Date

Printed Name

Relationship if NOT Patient

COAST SURGERY CENTER