Wright State Physicians
SURGERY

Communication/Privacy Consent Form

Patient Name _____ DOB _____

Occasionally it is necessary that we call patients regarding a surgery, appointment time change, test results, and/or billing matters. When communicating your personal health information, we follow the HIPAA regulations, which require confidential and direct communication to you unless otherwise specified by you.

With the number of patients who have voice mail, answering machines, etc., please complete the following questionnaire so that we may contact you in the most efficient way possible.

May we leave a message on your answering machine at your home?	YES	NO	N/A
May we leave a message on you cell phone?	YES	NO	N/A
May we leave a message on your spouse's cell phone?	YES	NO	N/A
May we call you at work?	YES	NO	N/A
May we leave a message on your voice mail at work?	YES	NO	N/A
If we call you at home, and you are unavailable, may we leave a message with another person?	YES	NO	N/A

If you are available by pager or cell phone, list the phone numbers below:

Pager#:_____ Cell#:_____

Please list the person or persons (including spouse, if applicable) that you authorize us to release information, their relationship to you and their phone numbers.

Name	Relationship to you	Phone Number(s)

_____ _____

Patient (or Guardian) Signature Date