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P290A PATIENT INFORMATION COMMUNICATION FORM

Name:	Home Phone:
Address:	City/State/Zip:

Alternate Communication Method or Location:

Revised Date: Patient Initials:

- ☐ No alternate communications; use address & telephone numbers as provided on registration form.
- ☐ Use alternate telephone number (specify):_____
- ☐ Use alternate address (specify):_____
- ☐ Send all communications in writing via U.S. mail
- ☐ Send all communications in writing via electronic mail to:_____

If voicemail, an answering machine, or someone other than patient answers the telephone:

- ☐ Ok to leave the name of the office and the reason for the call
- ☐ Leave the name of the office as the caller and request that I call you back
- ☐ Leave the office number only and request that I call you back
- ☐ Do not leave any messages, either on voicemail, a machine or with another person; do not identify this office as the caller

Restricted Disclosures of Patient Information:

Revised Date: Patient Initials:

Information	Restriction

Family Members / Friends Involved in My Care:

Revised Date: Patient Initials:

- ☐ Ok to disclose information to any individual who states that they are a family member or friend.
- ☐ Ok to disclose information to only the following family members or friends (check all that apply):
  - ☐ Spouse ☐ Any children ☐ Any parents ☐ Any siblings
  - ☐ Other (specify by name)
- ☐ Do not disclose information to any individual, regardless of relationship.

Acknowledgement of Receipt of Notice of Privacy Practices:

- ☐ I have received the Notice of Privacy Practices

Signature: _____ Date: _____

Patient/Spouse/Financially Responsible Party

Relationship, if other than Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Guardian ☐ Other: (specify):

- ☐ Patient refuses, or is unable, to acknowledge receipt of the Notice of Privacy Practices.

Employee Signature: _____ Date: _____