Washington University Physicians®

Washington University Patient Communication Form*

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave detailed telephone messages (i.e. lab results) when possible. There are also times where you may want us to communicate labs, medication, treatment plans, appointment or billing information to a trusted family member. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine, voice mail system, or with a trusted family member.

* Please note, this form is valid for all entities and providers comprising Washington University Physicians.

_____ _____

Patient Name ***Date of Birth***

Please choose one of the following for the providers and staff:

❒ **I DO CONSENT** all Washington University Physicians and any of its associated providers to leave detailed telephone messages regarding my personal health information (PHI) using the following options: (Provide the information below and initial each one that you want us to use for messages).

- Home phone number:_____Initials_____
- My cell phone number:_____Initials _____
- My work phone number:_____Initials _____
- Spouse name and phone number:_____Initials _____
- Name/Relationship and phone number:_____Initials _____
- Name/Relationship and phone number:_____Initials_____

This will remain in effect until you rescind it in writing.

_____ _____

Patient and/or Patient's Representative Signature ***Date***

❒ **I DO NOT CONSENT** for my provider to leave detailed telephone messages regarding my personal health information (PHI).

_____ _____

Patient and/or Patient's Representative Signature ***Date***

❒ **I DO NOT CONSENT** for my provider to communicate messages regarding my personal health information (PHI) to family members.

_____ _____

Patient and/or Patient's Representative Signature ***Date***

❒ **REVOCATION OF PRIOR CONSENT:** I wish to rescind or stop any prior consent to leave detailed telephone messages or communicate with family regarding my personal health information (PHI).

_____ _____

Patient and/or Patient's Representative Signature ***Date***