RIVERSIDE MEDICAL CLINIC

Authorization to Contact Information

PATIENT NAME: _____ **DOB:** _____

CHART NO.: _____ **DR:** _____ **APPT:** _____

Dear Patient,

You have the right to specify how and when we communicate with you about your medical care/services. For example, you can ask that we only contact you by telephone to discuss appointments, results or other medical information. Please review the following choices and indicate to us which method of communication is best for you.

STANDARD COMMUNICATION

_____ Standard Communication: All information on my account can be used to communicate with me, including address and home telephone number. My work telephone number may be used for messages.

RESTRICTED COMMUNICATION

_____ Only contact me by telephone at: _____

_____ Do not send mail to my home address. Only send written communications regarding my medical information to the address listed below:

Street: _____

Apt. or Suite: _____

City: _____ Street: _____ Zip: _____ - _____

_____ Special Instructions:

_____

_____

_____

_____

My signature below authorizes the doctor and/or staff member to communicate in the method indicated above. This includes:

- Stating that he/she is associated with the doctor's office and/or Riverside Medical Clinic to any person or answering device that may answer the telephone.
- Sharing the information regarding my appointments, test results or other medical information with any person or answering device that may answer the telephone.

Signature: _____ Date: _____