

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

REVOCAATION 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