



PATIENT DECLARATION OF COMMUNICATION PREFERENCES

Patient Name: _____ Date of Birth: _____

Our communications with you will include telephone calls (live and recorded) made to your home and/or cell phone, messages left on your answering machine or with the person answering your phone, and written correspondence (example: appointment reminders, statements, etc) mailed to your home. We will only discuss information regarding your care with the individuals listed below, if you so choose.

- I consent to the above methods of communication
- I give my permission to leave test results on my home and/or cell phone

-
- Call me at the following number (do not call me at my home number) _____
 - DO NOT leave a message on my answering machine
 - DO NOT leave a message with anyone else answering my phone
 - DO NOT mail reminder cards to me

- You may discuss my care only with the following people:
Name: _____ Relationship: _____
Name: _____ Relationship: _____
- You MAY NOT discuss my care with anyone

"I understand that Tri County OB GYN respects my right to privacy, and will make reasonable efforts to accommodate these preferences, as outlined in the Notice of Privacy Practices."

X _____
Patient/ Representative Date