Date:				
Patient Name: Date of Birth:				rth:
Parent/Legal Guardian Name fo	or Minor Patients:			· · · · · · · · · · · · · · · · · · ·
Our current Notice of Privacy P appointments. In some cases, i information. Please indicate bel	t may become necessary to c	ontact you	by telephone to	
	Select appropri	ate box belo	<u>ow</u>	
Phone: ()	□ Home	□ Cell	□ Work	Initials:
Phone: ()	⊟ Home	□ Cell	□ Work	Initials:
Minor's Phone (patients betwee	n 12 and 17): ()			Initials:
ages of 12 and 17.  ☐ I consent and authorize Jo	 ohn Muir Health Physician Ne	twork and t	heir staff to leav	e a detailed telephone
☐ I do not consent or author machine or with a designate	dical care or my minor child at rize detailed messages regarded person. I wish to be contacted may be delays in receiving the individuals you designate	ding my me eted persona ng my result	dical care to be ally at the numbe s or medical car	left on voicemail, my answer er(s) listed above (initial each e.
	ohn Muir Health Physician Ne est results, prescriptions, refe	twork to dis	close and/or rel	ease any medical information
Designee:	Relationship:		PI	none:
Designee:	Relationship:		PI	none:
Designee:	Relationship:		PI	none:
Designee:	Relationship:		PI	none:
This communication pre	eference will remain in effect fo	r three years	s unless you resc	ind or provide a change.
Signature		Date		
3197020B (9/16/19)			-	PATIENT LAB
JOHN MUIR HEALTH				
CONFIDENTIAL C	OMMUNICATION PREFEREN	ICE		