

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Legal Guardian Name for Minor Patients: \_\_\_\_\_

Our current Notice of Privacy Practices allows us to call you with a courtesy reminder regarding upcoming appointments. In some cases it may become necessary to contact you by telephone to discuss other medical information. **Please indicate below which number(s) we may contact you at:**

Select appropriate box below

Phone: ( ) \_\_\_\_\_  Home  Cell  Work Initials: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_  Home  Cell  Work Initials: \_\_\_\_\_

Minor's Phone (patients between 12 and 17): ( ) \_\_\_\_\_ Initials: \_\_\_\_\_

We take patient privacy laws very seriously, and the State of California limits what types of health information we can share with parents about their teen. For this reason, we will maintain an exclusive phone number for teens between the ages of 12 and 17.

- I consent and authorize** John Muir Physician Network and their staff to leave a detailed telephone message regarding my medical care or my minor child at the number(s) listed above (initial each option).
- I do not consent or authorize** detailed messages regarding my medical care to be left on voicemail, my answering machine or with a designated person. I wish to be contacted personally at the number(s) listed above (initial each option). I understand that there may be delays in receiving my results or medical care.

**Please indicate below any specific individuals you designate to receive medical information on your behalf**

- I do not consent or authorize** my medical information to be disclosed to any other individuals.
- I consent and authorize** John Muir Physician Network to disclose and/or release any medical information or correspondence, including test results, prescriptions, referrals, medical records etc., to the following specified person(s) who are at least 18 years or older.

**Designee:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Designee:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Designee:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Designee:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

***This communication preference will remain in effect for one year unless you rescind or provide a change.***

Signature \_\_\_\_\_ Date \_\_\_\_\_

3197020B (2/10/17)



**CONFIDENTIAL COMMUNICATION  
PREFERENCE**

PATIENT LABEL