

Place Patient Identification Label Here

**Patient's Preferences
Regarding their PHI**

Telephone Communication Preferences

| Location | Can we call you here? | | Can we leave a message? | |
|--------------|------------------------------|-----------------------------|------------------------------|-----------------------------|
| Home | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Work | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mobile Phone | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Mail Communication Preferences

May we send mail to your home address? *(If no, please provide an alternate mailing address below.)* Yes No

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

| | Name | Telephone |
|------------------------------------|-------|-----------|
| <input type="checkbox"/> Spouse | _____ | _____ |
| <input type="checkbox"/> Caretaker | _____ | _____ |
| <input type="checkbox"/> Child | _____ | _____ |
| <input type="checkbox"/> Parent | _____ | _____ |
| <input type="checkbox"/> Other | _____ | _____ |

In order to verify accurate health and surgical information, we will be asking you various questions in different settings. The pre-op holding area and post anesthesia area are areas where you and other patients will be asked questions.

Will this be a problem for you? ___ Yes ___ No
If answered yes, a private consultation will be provided for you.

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.
I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Patient or Personal Representative Signature

Printed Name

Date

Relationship to Patient

**Patient's Preferences
Regarding their PHI**

| | |
|-------|------------------|
| _____ | Patient Contact: |
| _____ | Relationship: |
| _____ | Contact Number: |
| _____ | Notes: |