Patient Communication Preferences

TO OUR PATIENTS:

You have the right to request that Alister A. George, MD communicate with you by alternative means or at alternate locations. Please use the attached form to tell us how you prefer to communicate with us.

You may also use this form to tell PeaceHealth who is involved in your care so that we can provide them with the information they need to assist you. IF you choose to identify the individuals who are involved in your care on this form, you should be aware of the following:

- By completing and signing this form, you are indicating that your doctor and other staff (nurses, office assistants, etc.) may share limited information with the people named on the form.
- This form is completely optional. You are **NOT** required to complete it in order for us to share limited information with people involved in your care at home and elsewhere. This will primarily be verbal information but may also include some written or printed information (e.g. care instructions).
- This form will not expire. We will act upon the information your provide on this form unless you inform us that it has changed.
- **This form is not a legal authorization, consent, release, or agreement.**
- This form does **NOT** grant the people named on it the right to obtain access to or copies of your health records.
- If your family member or friend wishes to obtain all or part of your health records, you must formally authorize their release by completing a Medical Records Request form.

(This page goes to patient – Do not scan into record)

Patient Communication Preferences

PATIENT: You have the right to request that Alister A. George, MD communicate with you by alternative means or at alternate locations. You may also use this form to tell us who is involved in you care so that we can provide them with the information they need to assist you. **This form is optional and does not expire.** Your request will be in effect until you notify us of a change. We will accommodate all reasonable requests. See previous page for more information. You are **NOT** required to complete it in order for us to share limited information with people involved in your care, unless you object.

I request that my medical and/or billing information be communicated to me by the following means or locations (check all that apply):

☐ You may contact me at my ☐ **HOME** ☐ **CELL** ☐ **WORK** phone number. (Check all that apply)

☐ You may leave a message with medical information on voice mail/answering machine at my ☐ **HOME** ☐ **CELL** ☐ **WORK** phone number. (Check all that apply)

Numbers: Home: _____ Cell: _____ Work: _____

☐ Send all information to this address: _____

_____

_____

☐ Email information by using my Alister A. George, MD patient portal account

☐ Fax information to: _____

☐ Other: _____

☐ You may give information to the following individuals involved in my care:

1. Name _____ Relationship: _____ Phone: _____
   - ☐ May leave a message with another member of the household.
   - ☐ May leave a message on an answering machine or voice mail.
2. Name _____ Relationship: _____ Phone: _____
   - ☐ May leave a message with another member of the household.
   - ☐ May leave a message on an answering machine or voice mail.

X_____

Signature (Patient or Person Authorized to Sign for Patient & Relationship) **Date/Time**