HMA
huguley medical associates

CONFIDENTIAL COMMUNICATION REQUEST

This form indicates the means of communication that I prefer to remind me of my appointment, communicate test results and follow-up visits.

I consent to the release of any medical information or test results to the following persons:

- My Spouse:____
- My child/children:____
- My parents:____
- Other:____

I wish to be contacted in the following manner (check all that apply)

- Home Telephone:____
  - Permission to leave a message with detailed information
  - Leave Name/Doctor with call back number **ONLY**
- Cell Phone:____
  - Permission to leave a message with detailed information
  - Leave Name/Doctor with call back number **ONLY**
- Work Telephone:____
  - Permission to leave a message with detailed information
  - Leave Name/Doctor with call back number **ONLY**
- Patient Portal
  - Email Address:____
- When unable to contact me by phone, a written communication may be sent to:
  - Home address (on file)
  - Alternate Address:
    ____
    ____
    ____

________________________________ ________________________________
Patient Signature Date

________________________________ ________________________________
Print Name Date of Birth

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