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 Health 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 Health 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 three years unless you rescind or provide a change.

Signature _____ Date _____

JOHN MUIR HEALTH

CONFIDENTIAL COMMUNICATION PREFERENCE

PATIENT LAB