Between the Bridges Healing Center
45 Teton Lane Mankato, MN 56001
507-388-7488 Fax (507) 388-5680

Patient preference regarding Communication of Health Information

Patient Name: _____ **DOB:** _____

WHO TO CONTACT:

I hereby give **Between the Bridges Healing Center LLC** permission to disclose and discuss any information related to my medical information to/with the following family member(s), other relative(s) and/or close personal friends(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ I do not wish to give permission for additional family members, relatives or close personal friends to have any access to any information regarding my medical condition or treatment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information not listed above or approved under the HIPAA Privacy Act, will require specific authorization prior to disclosure of any information.

Signature of Patient or Legal representative: _____ Date: _____

HOW TO CONTACT

I wish to be contacted in the following manner(s) pertaining to my healthcare:

Home Telephone: _____ _____ OK to leave a message with detailed information _____ Leave message with a call back number only	**Work Telephone:** _____ _____ OK to leave a message with detailed information _____ Leave message with a call back number only
Mobile/Cell Phone: _____ _____ OK to leave a message with detailed information _____ Leave message with a call back number only	
_____ **Written Communication:** ____ OK to mail to my home address: _____ ____ OK to fax to this number: _____	
_____ **E-Mail Communication:** (must sign additional electronic communication consent) ____ OK to email to this email address: _____	