



# Between the Bridges Healing Center

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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:

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