

PREFERRED CONTACT METHODS TO ASSURE OUR PATIENT PRIVACY

Patient Name (Please Print): _____

**I wish to be contacted in the following manner (check all that apply)
Please check the best and second best (2nd) phone numbers to contact you daytime**

- Home Telephone _____ (best , 2nd best number to call)
 O.K. to leave message with detailed information (such as appointment time and reasons)
 Leave message with call-back number only
- Work Telephone _____ (best , 2nd best number to call)
 O.K. to leave message with detailed information (such as appointment time and reasons)
 Leave message with call-back number only
- Mobile/Cellular Telephone _____ (best , 2nd best number to call)
 O.K. to leave message with detailed information (such as appointment time and reasons)
 Leave message with call-back number only
- Written Communication
 O.K. to mail to my home address
 O.K. to mail to my work/office address
 O.K. to fax to this number _____
- Other _____

Our office will NOT share any of your information without your permission. For example, if you ask your spouse to call us to discuss your insurance payment status, we will not be able to discuss with him unless you sign following permission.

I give Dr. Lee and her staff permission to discuss my medical / financial information with the following person(s):

Name _____ Relationship: spouse parents offsprings
 other: _____

Medical information only
 Financial information only
 Both Medical & Financial information

Name _____ Relationship: spouse parents offsprings
 other: _____

Medical information only
 Financial information only
 Both Medical & Financial information

Patient Signature _____ Date _____