Pine Springs Health
Exceptional Care Through Healthy Connections

# Communication Preferences

| DOB (mm/dd/yyyy) | Today's Date | |
|---|---|---|
| **Last Name:** | **First:** | **Middle:** |
| **Cell Phone:** _____ | **Home Phone:** _____ | **Other:** _____ |

| **Pine Springs Health may: (check all that apply)** | | | |
|---|---|---|---|
| Leave **medical** information on voicemail: | ☐ Cell Phone | ☐ Home Phone | ☐ None |
| Leave **billing** information on voicemail: | ☐ Cell Phone | ☐ Home Phone | ☐ None |

**If there is anyone you would like for us to be able to speak with regarding certain aspects of your care, please indicate below:**

*I authorize Pine Springs Health to speak to the following people in person or by telephone about…* ***(Please specify):***

| **Name* | *Relationship to Patient:* | *Phone Number:* |
|---|---|---|
| | | |

***Regarding:** ☐ **Schedule or cancel appointments** ☐ **All information** ☐ **Other:**_____

| **Name* | *Relationship to Patient:* | *Phone Number:* |
|---|---|---|
| | | |

***Regarding:** ☐ **Schedule or cancel appointments** ☐ **All information** ☐ **Other:**_____

**The authorization may be changed or revoked in writing at any time. It will remain in effect until that time. By Signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.**

Patient Signature: _____ Date: _____

Legal Guardian: _____ Date: _____