Request to Communicate

I authorize the clinic indicated above to contact me regarding clinical services in the means provided below. These messages may include appointment reminders, schedule changes or other personal health information. I understand it is my responsibility to notify the clinic should this information change. **I understand I do not have to provide any of the communication sources.**

Home Phone: _____ ☐ You may leave a detailed message
Ex: 123-456-7890

Cell Phone: _____ ☐ You may leave a detailed message
Ex: 123-456-7890

Work Phone: _____ ☐ You may leave a detailed message
Ex: 123-456-7890

Email: _____ ☐ You may leave a detailed message

Please Note: *If you do not mark the box to leave a message, we will not leave a message.*

Please Note: *If a spouse/family member/POA completes the form, their name should be listed so that we can talk to them.*

Do you give permission for us to contact or leave information with another person?

☐ Yes ☐ No

List name of person(s): _____

*You can list as many people as you would like.

Relationship of person: _____

Contact phone number: _____
Ex: 123-456-7890

_____ _____ _____
Signature of Patient/Patient Representative | Date/Time | Relationship of Patient Representative

DCH Health System®

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