DCH Diabetes and Nutrition Education Center

DCH Health System

Request to Communicate

ΔT0001
DT0001

Today's Date:_____

I authorize the DCH Diabetes and Nutrition Education Center to contact me regarding clinical services by the means provided below. By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I understand that information transmitted via telephone, text message, or e-mail can be intercepted and recorded by unrelated third parties. I authorize my healthcare provider to utilize this unsecured method of communication for limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual if I am unavailable at the number provided by me for the purposes shown above. I understand it is my responsibility to notify the DCH Diabetes and Nutrition Education Center should this information change. I understand that I **do not** have to provide any of the communication sources.

Complete and check all that apply.

Home Phone: _____ ☐ You may leave detailed message

Cell Phone: _____ ☐ You may leave a detailed message or send text

Work Phone: _____ ☐ You may leave a detailed message

Email: _____ ☐ You may send a detailed message

Would you like to enroll in the patient portal? ☐ Yes ☐ No

Do you give us permission to contact or leave a message with someone other than you?

If so, please provide name and phone number of this person _____

Signature of patient or patient representative: _____Date_____