CONTACT PERMISSION
OFF GRID DOC

OFF GRID DOC STRIVES TO MAINTAIN YOUR PRIVACY. IN COMPLIANCE WITH FEDERAL PRIVACY REGULATIONS AND TO MAKE OUR COMMUNICATION WITH YOU AS CONVENIENT AS POSSIBLE, WE REQUEST THAT YOU COMPLETE THE FORM BELOW.

DO YOU CONSENT TO THE FOLLOWING FORMS OF COMMUNICATION BETWEEN OFF GRID DOC AND YOURSELF?

TEXT MESSAGING	YES _____	NO_____	PHONE # _____
VIDEO CALLS	YES _____	NO_____	EMAIL _____
EMAIL	YES _____	NO_____	EMAIL _____
TELEPHONE VISIT	YES _____	NO_____	PHONE # _____

IF WE NEED TO CONTACT YOU WITH RESULTS OF TESTS OR OTHER HEALTH INFORMATION, MAY WE

CALL YOUR HOME?	YES _____	NO_____	PHONE # _____
CALL YOUR WORK?	YES _____	NO _____	PHONE # _____
CALL YOUR CELL?	YES _____	NO _____	PHONE # _____
CALL OTHER?	YES _____	NO _____	PHONE # _____
LEAVE A MESSAGE AT HOME?	YES _____	NO _____	
LEAVE A MESSAGE AT WORK?	YES _____	NO _____	
LEAVE A MESSAGE ON CELL?	YES _____	NO _____	
LEAVE A MESSAGE AT OTHER?	YES _____	NO _____	

IF WE MAY DISCUSS YOUR PROTECTED HEALTH INFORMATION WITH OTHERS, PLEASE GIVE US THE NAME AND NUMBER OF THOSE INDIVIDUALS WITH WHO YOU GIVE US PERMISSION TO DISCUSS YOUR RESULTS.

NAME	NUMBER	RELATIONSHIP

I AGREE THAT I MAY BE NOTIFIED OF MY PROTECTED HEALTH INFORMATION IN THE LOCATIONS THAT I INDICATED ABOVE AND THAT MY PROTECTED HEALTH INFORMATION MAY BE DISCUSSED WITH THE INDIVIDUALS INDICATED ABOVE.

_____ _____

SIGNATURE PATIENT/ PERSONAL REPRESENTATIVE DATE

_____ _____

NAME OF PATIENT DATE OF BIRTH