Sharing Information with Family or Friends

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Medical condition and your diagnosis (including treatment, payment and health care operations): Please list the family members and/or other persons, if any, whom you may want us to inform about your general

 Name Relationship Phone Number

 Name Relationship Phone Number

 **Please list the family members and/or other persons, if any, whom we may inform about your medical condition**

1. ONLY IN AN EMERGENCY:

 Name Relationship Phone Number

 Name Relationship Phone Number

**3.** Results or other health care information: Please list the telephone number(s) where you want to receive calls about your appointments, lab and x-ray:

**4.**

Can confidential messages (for example, appointment information) be left on your answering machine?

Yes

 No

**5.** Can we send you the following information electronically?

Please note if other individuals have access to the contents of this electronic mail address, those individuals may have access to any information we send at that address. High Point Occupational Health will not be responsible if such individuals access information sent to the electronic mail address you provide.

* Information about your medical conditions: Yes No
* Information about health-related benefits or services that may be of interest to you: Yes No
* Information about potential treatment options or alternatives: Yes No Please note: while we may ask you from time to time if there have been any changes to this information, it is your responsibility to update this information as needed.

I understand that HP Occupational Health is not required by law to accept my request, but will make every effort to accommodate reasonable requests for alternative means of communication. If alternative means of billing have been requested, HPOCC may request information as to how payment will be handled before accommodating the request. I understand that if this request is accepted and put into place, it may make HPOCC ability to communicate with me more difficult and/or less effective.

Patient or Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Receipt\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_