CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

PATIENT COMMUNICATION FORM - ADULT

The purpose of the form is for you to document your preferences regarding 1) how we communicate with you and 2) if/how you would like us to communicate with your friends and family regarding your care. Filling out this form will allow us to verbally share information with the individuals you specify. Any request to disclose written information, including but not limited to any information in your medical record, will only occur after a written authorization has been completed and signed. You may revoke this permission at any time by completing a new Patient Communication Form.

COMMUNICATIONS WITH ME

Telephone Contact# Home ( )_____ Cell ( ) _____
Preferred: Home ____ Cell____

If unable to reach me:
_____ I give practice staff consent to identify themselves and leave verbal messages for me or to send text messages to me. I understand messages may include information and dates or future appointment or test results.

_____ I do not give practice staff consent to identify themselves and leave messages for me or to text me.

COMMUNICATIONS WITH OTHERS

By signing below, I give permission for my care team to **discuss** my care (including diagnosis, diagnostic test results, examination information, claim information, and appointment confirmations) with the individuals specified below - if the individuals request information or if my care team believes it is in my best interest. This permission is specific to **my current treatment or care at any CMU Health location.**

(1) Name:_____ Relationship/Phone: _____

(2) Name:_____ Relationship/Phone: _____

(3) Name:_____ Relationship/Phone: _____

MAILINGS

_____ I **do** want to receive mailings from my doctor's office at my home address.
_____ I **do not** want to receive any mailings from my doctor's office at my home address. Please send them to my attention at:

_____

I have carefully read and understood all the above. All my questions have been answered. I understand that the individuals listed above may continue to receive verbal communications regarding any information they request, and, if I have selected this option, that all mailings will be sent to the address above, until I notify the office, in writing, of my decision to change it.

Patient Name (print): _____ **Date of Birth:** _____/_____/_____

Patient Signature: _____ **Date:** _____

Legal Representative Name (print): _____

Legal Representative Signature: _____ **Date:** _____

EMERGENCY CONTACT

Name (print): _____ **Relationship to Patient:** _____ **Cell:** _____