

PATIENT COMMUNICATION CONSENT FORM

I agree to allow Dr. Cohen and his staff to contact me using the following methods regarding my personal health information, evaluation and treatment. I authorize/do not authorize Dr. Cohen and his staff to leave messages for me when I am unavailable as indicated below.

Check to Confirm Approval of Method	Method	Number/Address	Leave Messages
_____	Home Phone	(_____) _____ - _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Cell Phone	(_____) _____ - _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Work Phone	(_____) _____ - _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Alternate Phone	(_____) _____ - _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Email	_____ @ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

I authorize Dr. Cohen and his staff to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Phone Number
_____	_____	(_____) _____ - _____
_____	_____	(_____) _____ - _____
_____	_____	(_____) _____ - _____

EMERGENCY CONTACT ONLY:

Name: _____

Phone: _____

By my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent Form. I understand the risk associated with different methods of communication, especially email, and consent to the communications outlined in this Consent Form.

Patient Name Printed

Date

Patient/Authorized Signature

Relationship to Patient