EWbc Elizabeth Wende Breast Care
Breast Imaging Excellence

COMMUNICATION PREFERENCE FORM

Patient Last Name:	Patient First Name:	Chart #: for office use only	Date of Birth: Month____ / Day____ / Year____

Patient Information Authorization

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). Completion of this form tells us your preferences with regard to telephone messages and gives us information about individuals you have authorized to speak to us about your health care. Further authorization may be needed under more specific circumstances.

I wish to be contacted by phone in the following manner (check all that apply):

Phone numbers with area codes:	Check one	Check one	
Primary number:	☐Cell ☐Home ☐Work	☐Leave message with call back number only	☐OK to leave detailed message*
Secondary number:	☐Cell ☐Home ☐Work	☐Leave message with call back number only	☐OK to leave detailed message*
Other number:	☐Cell ☐Home ☐Work	☐Leave message with call back number only	☐OK to leave detailed message*
* On answering machine/voicemail or with any individual, other than yourself, who answers the telephone.			
☐EWBC may fax Protected Health Information	Fax number:		

Other individuals I authorize to take messages or discuss Protected Health Information are

(check and list all that apply):

Name	Relationship (i.e. spouse, parent, son, daughter, etc)	This information may include (check all that apply):
		☐All information (with the exception of Genetics – a separate form is required) ☐Appointment Information ☐Billing Records ☐Diagnosis and Lab results ☐Medical Records
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Patient Signature:___________________________________ **Date**: Month____ / Day____ / Year___