Breast Care Center – Cedar Valley Medical Specialists

Patient Communication Form for Privacy Practices

Our office will make an effort to notify you of your test/lab/procedure/etc. results if necessary. Please advise us of the best method of communication and who may and/or may not receive these communications.

We will use the phone numbers, address and email you have provided.

Please Mark the Best Method of Communication:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Mail ☐ Email

I give permission for the following to receive my Personal Health Information:

Spouse: ______________________________ Phone: ______________________________

Significant Other: ______________________________ Phone: ______________________________

Child: ______________________________ Phone: ______________________________

Child: ______________________________ Phone: ______________________________

Child: ______________________________ Phone: ______________________________

Friend: ______________________________ Phone: ______________________________

Parent: ______________________________ Phone: ______________________________

Other: ______________________________ Phone: ______________________________

DO NOT give my Personal Health Information to the following:

____

____

______________________________ ______________________________

Patient's Signature and/or Guardian **Date**

______________________________ ______________________________

Printed Name **Patient's Date of Birth**

____

Guardian's relationship to patient if applicable