Clinch River Health Services

Patient Preferences for Receiving Communication

PATIENT NAME: _____ DATE OF BIRTH: _____

Please contact me as follows: [ ] Home [ ] Cell [ ] Work [ ] Other Number: _____

You may choose any that apply:

[ ] Leave detailed message [ ] Leave call-back number only

[ ] Do not leave message

You have my permission to discuss my care with:

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

You have my permission to discuss my account balance and billing with:

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Witness Signature Date