

PATIENT REQUEST FOR CONFIDENTIAL CHANNELS OF COMMUNICATION

Patient Name: _____

I understand that when Dr. Goldstone contacts me for any reason, including appointments, she will do so by telephone, email, or fax.

I hereby request to receive such communications as follows:

1. By Telephone (check all that apply):

- at home telephone number: _____
- at work telephone number: _____
- via cell phone telephone number: _____
- other _____ telephone number: _____

When providing information by telephone, I hereby consent to the following (check all that apply):

- leave message on my voicemail to call Dr. Goldstone back
- leave message on my voicemail providing test/procedure information or results
- leave message with another person at this number to call Dr. Office back
- leave message with the following person(s) providing test/procedure info or results

Name of Person(s)	Relationship to Patient
_____	_____
_____	_____
_____	_____

2. By Email (check all that apply):

- a message to contact Dr. Goldstone
 - a message that includes test/procedure information or results
- Email address: _____
- Email address: _____

3. By Fax (check all that apply):

- a message to contact Dr. Goldstone
 - a message that includes test/procedure information or results
- Fax number: _____
- Fax number: _____

I certify that I am the patient above that is providing consent:

Patient's Name (print): _____ Signature: _____

Date: _____