Advanced Medical Thermography
CONTACT INFORMATION

Patient Name: _____

As allowed by the Privacy Regulations, I wish for this office to provide the following alternative means of communicating my Protected Health Information:

Mailing address if different than listed on questionnaire :

_____

Contact phone numbers:

Home: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO
	Review Report?	YES	NO
Work: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO
	Review Report?	YES	NO
Cell: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO
	Review Report?	YES	NO

Other person authorized to receive message / information: _____

Relationship to patient: _____

How would you like to be reminded when it's time for your follow-up appointments?

E-mail	YES	NO
Phone (see above)	YES	NO
Mail	YES	NO

Would you like to receive E-mails regarding special events, special offers, and health information? YES NO

I have the following additional requests for confidential communications regarding my Protected Health Information: (please explain)

_____

_____

_____ _____

Signature Date