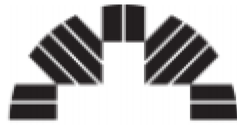

MOUNT CARMEL

Patient Confidentiality Release

Patient Name (Last, First):	Birth Date (mm/dd/yyyy):	Date (mm/dd/yyyy):

Please respond to the following questions regarding alternative means of contact:

May we leave messages at home with other residents?	☐YES	☐NO
May we leave personal health information on your answering machine/voicemail?	☐YES*	☐NO
May we contact you via e-mail or cellular telephone?	☐YES**	☐NO
May we contact you via text message?	☐YES**	☐NO

**Appointment reminders will be left on voicemail.*
***We cannot ensure the confidentiality of information shared by these means.*

Please list below any friend or family member that you involve in your medical care (if applicable):

Assist with medical / clinical decisions: Name: ____

Relationship:___________________________________**Phone Number:**_______________________

Assist with financial / paying of medical bills: Name:____

Relationship:___________________________________**Phone Number:**_______________________

I understand that when I sign this document that I am confirming that all information completed by me is correct and I authorize contact in the means identified above.

Signature of Patient or Patient Representative:___________________________________**Date:**__________

Relationship of Legal Representative to Patient (e.g., parent, guardian, other, please explain):

____**Date:**__________