PATIENT CONFIDENTIALITY: It is the policy of PinnacleHealth to release confidential information only with the authorization of the patient, unless otherwise permitted or required by law.

I understand that I will receive correspondence through the U.S. Mail. I authorize PinnacleHealth to provide or leave messages regarding scheduling or routine medical information pertaining to my care, such as normal test with the following authorized individual(s).

Please list names and relationship of authorized person(s) (e.g.: spouse, parent, child) with whom we may discuss your medical care.

Name:	Relationship:	Medical Information to be shared:	Method
_________ _________ First Last	_________	☐ appointment information ☐ all medical information ☐ information restricted to (please indicate): __________________	☐ Telephone ☐ Phone Message ☐ In Person
_________ _________ First Last	_________	☐ appointment information ☐ all medical information ☐ information restricted to (please indicate): __________________	☐ Telephone ☐ Phone Message ☐ In Person
_________ _________ First Last	_________	☐ appointment information ☐ all medical information ☐ information restricted to (please indicate): __________________	☐ Telephone ☐ Phone Message ☐ In Person

CONTACT INFORMATION:

Please indicate where we may attempt to call you:

Home	☐ YES ☐ NO	Telephone Number: ( ) ______-________	Message may be left	☐ YES ☐ NO
Work	☐ YES ☐ NO	Telephone Number: ( ) ______-________	Message may be left	☐ YES ☐ NO
Cell Phone	☐ YES ☐ NO	Telephone Number: ( ) ______-________	Message may be left	☐ YES ☐ NO

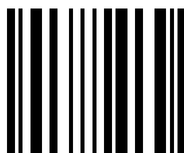
I understand that I am responsible to notify PinnacleHealth when any of this information changes.

Patient ____________________ ________________ ______ ______

signature print name date time

Parent/Guardian____________________ ________________ ______ ______

signature print name date time



PATIENT IDENTIFICATION

Patient Name: ____________________

MR Number: ____________________

Date of Birth: ____________________