Mountain View Surgery Center of Gilbert

2450 E Guadalupe Road Suite 101*Gilbert AZ*480-398-8456

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home #

Work # _____

Mobile # _____

Other _____

E-Mail Communication Preferences

Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Mountain View Surgery Center of Gilbert, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.

If an email address has been provided, Mountain View Surgery Center of Gilbert, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Mountain View Surgery Center of Gilbert when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient's Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? (**If no, please provide an alternate mailing address below**.)

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information and/or financial information? (Check all that apply)

	Name:	**Telephone**
Spouse	_____	_____
Caretaker	_____	_____
Child	_____	_____
Parent	_____	_____
Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**