HeartCARE
CENTER OF THE VALLEY

PATIENT CONTACT PREFERENCES

Patient Name _____ Date of birth _____

I wish to be contacted in the following manner (check all that applies):

Home Phone: _____

__ OK to leave message with detailed information

__ Leave message with call-back number only

Cell Phone: _____

__ OK to leave message with detailed information

__ Leave message with call-back number only

Other: _____

I understand that I may revoke this authorization at any time, which will then apply to any future disclosures of my protected health information. I have been given the opportunity to review the Notice of Privacy Practices available on the website and in the office.

_____ _____

Patient/Guardian Signature Date