DALLAS ASTHMA & ALLERGY CENTER

Patient Information Contact Form

Name______________________________________ Date______________

At which of the following numbers do we have permission to contact you?

Y / N Home ______________________
Y / N Cell phone ______________________
Y / N Work ______________________
Y / N Other ______________________

May we leave a message for you at work? Y / N
May we leave a message for you at home? Y / N

In addition to you and your insurance company, with whom may we discuss your health information?

Y / N Spouse Name/Telephone ____________________________________
Y / N Caregiver Name/Telephone ____________________________________
Y / N Child Name/Telephone ____________________________________
Y / N Parent Name/Telephone ____________________________________
Y / N Other Name/Telephone ____________________________________

Do you have any health information that you would like to keep confidential from any person(s)? Y / N
If so, please describe: ____

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

I acknowledge that I have read and received a copy of the Privacy Notice.

____ ________________________
Patient or Personal Representative Signature Date

____ ________________________
Printed Name Relationship to Patient