Indiana Surgical Associates P.C.
Instructions for Communication Preferences

I authorize Indiana Surgical Associates P.C. doctors or staff to **leave messages** and/or **communicate with certain individuals** regarding my health information:

☐ YES May leave messages on my answering machine or voicemail:
☐ at HOME ☐ at WORK ☐ on my MOBILE/CELL Phone

May share my health information with the following individuals:
☐ My Spouse or Significant Other_____
☐ My Son or Daughter_____
☐ Relative_____Relation:_____
☐ Other_____Relation:_____

These messages or communications may include information such as test results, prescription refills, appointments, instructions regarding treatments or medications, and billing information.

☐ NO Please do not leave messages on my answering machine or voicemail and I prefer that my doctor or staff speak to only myself personally regarding any medical information.

I understand that I must notify Indiana Surgical Associates P.C. any time there are changes to this request, which would require a new form to be completed.

Patient Name (*Please Print*):_____

Date of Birth:_____

Signature:_____ Date:_____

Under the privacy protection act, we are not calling and releasing any of your health information to the individuals listed; this form allows us to speak to who you specifically indicate has your permission to contact us concerning you and your private health information. If someone contacts us, and they are not listed above, we will not be able to speak to them about you.