Western Connecticut Medical Group

HOW MAY WE CONTACT YOU REGARDING CONFIDENTIAL HEALTH INFORMATION?

(Note to Patient - This form will be used by all WCMG offices except Psychiatry)

Patient Name:______________________________ Date of Birth_________________________

Do you have any visual/hearing impairments? _____ If yes, please explain _________________

Lab of Choice _____________________ Pharmacy of Choice ________________________

Primary Care Physician_________________ Primary Language Spoken (if other than English) _____________

Email Address: ____
We only use our patient e-mail addresses for three purposes – to send you a satisfaction survey, to have you included in our database for our patient portal and for patient education

Please select all that apply:
Phone:
In the event I do not answer the telephone, I authorize this office to disclose my personal health information such as test results, medications, and appointments on the following voice mail and/or answering machine:

☐ **DO NOT Disclose any personal information on the voice mail and/or machine**

☐ Home Phone:___(____________)_______________________________________

☐ Cell Phone:____(____________)_______________________________________

☐ Work Phone:___(____________)_______________________________________

This office may disclose my health information to the following people:

Name:________________________Phone:__________________Relationship____________________

Name:________________________Phone:__________________Relationship____________________

Name:________________________Phone:__________________Relationship____________________

Mail: Only provide an alternate address if you would like health information mail to be sent to an address that is different than the home address we have on file. (not for billing purposes)
Alternate Address:____

____

Signature:____ Today's Date: _______________________
(Valid unless revoked in writing)

If not signed by the patient, please indicate your relationship to the patient : ______________________

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