

Communication Choices

Patient: _____ Date of Birth: _____

By completing and signing this form, I authorize Central DuPage Hospital, Central DuPage Physicians Group and their affiliates to leave messages containing medical information at the following phone numbers. I understand this document will be valid until I or my Personal Representative revokes this authorization in writing.

On my business/place of employment voice mail/answering machine Yes No (circle one)

On my home voice mail/answering machine Yes No (circle one)

On my cell phone voice mail Yes No (circle one)

In the space below, if desired, please indicate any personal "representatives/individuals who are permitted to receive or know information concerning your healthcare for the time period that this form is valid:

1) _____ Relationship: _____

Phone # _____

2) _____ Relationship: _____

Phone # _____

3) _____ Relationship: _____

Phone # _____

A personal representative as defined under the Health Insurance Portability Act of 1996 (HIPPA) is any family member, friend or individual designated by the patient to whom the patient's health information may be disclosed.

Print Name: _____ Relationship to patient: _____

Signature: _____ Date: _____

Place Patient Label Here