



NEDRA L RICE, M.D.    MARY ANN FRANKEN, M.D.    NGUYEN T. NGUYEN, D.O.    SONY BIJI, NP

**PATIENT COMMUNICATION PREFERENCES**

I wish to be contacted in the following manner(s) pertaining to my healthcare:

Mobile/Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
\_\_\_\_\_ Ok to leave a detailed message \_\_\_\_\_ Ok to leave a detailed message  
\_\_\_\_\_ Leave message with a call back number only \_\_\_\_\_ Leave message with call back number only

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Mailing Address: \_\_\_\_\_ Insurance Name: \_\_\_\_\_  
\_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
\_\_\_\_\_

**WHO TO CONTACT:** I hereby give Contemporary Women’s Care, P.A. permission to disclose and discuss any information related to my medical care to the following individuals:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Number: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Number: \_\_\_\_\_

**-OR-**

\_\_\_\_\_ I do not wish to give permission to other individuals to have access to any information regarding my medical condition or treatment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information not listed above or approved under the HIPAA Privacy Act, will require specific authorization prior to disclosure of any information.

Name of Patient or Legal representative: \_\_\_\_\_

Signature of Patient or Legal representative: \_\_\_\_\_ Date: \_\_\_\_\_