OB/GYNE
Associates of Lake Forest, Ltd.

COMMUNICATION REQUEST

Date: _____ Date of birth: _____

Name: _____

Patient's Phone: _____

Patient's Email: _____

When contacting you by phone, may we leave a message on voicemail to return our call?

□ **Yes** □ **No**

When contacting you by phone, may we leave a message with normal results on voicemail?

□ **Yes** □ **No**

How would you like to receive appointment reminders and confirmations?

□ **Call** □ **Text** □ **Email**

List anyone with whom we may share your PHI (private health information) through all forms of communication including electronic (phone, email, patient portal, etc)

Name/Relationship/Contact Phone Number:

1. _____
2. _____
3. _____

*_____ _____

Signature of Patient or Legal Representative **Date**