



Communicating with You

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail.**

Please check all boxes that you give Houston Center for Infectious Diseases permission to use for your communications:

<input type="checkbox"/> You may contact me by telephone	Phone Number: _____
<input type="checkbox"/> You may leave a message/voice mail	Phone Number: _____
<input type="checkbox"/> You may contact me by mail	
<input type="checkbox"/> You may contact me through email (ECW Patient Portal)	

If you give permission for us to communicate with anyone else, please complete the list below:

Name/Phone Number	Relationship	Options
1.		<input type="checkbox"/> Billing Information <input type="checkbox"/> Appointment Information <input type="checkbox"/> Medical/Health Information
2.		<input type="checkbox"/> Billing Information <input type="checkbox"/> Appointment Information <input type="checkbox"/> Medical/Health Information
3.		<input type="checkbox"/> Billing Information <input type="checkbox"/> Appointment Information <input type="checkbox"/> Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

Signature of Patient/Guarantor: _____ Relation to Patient: _____

Name of Patient/Guarantor (Print): _____ Date: _____