Mercy
MEDICAL CLINIC
A partner with Mercy Health Network–Centerville

Confidential Alternative Communications Request

Patient_______________________________________ Date of Birth _________________________

Contacting You About Your Medical Information

We may need to contact you about your (or your minor child's) medical information.
Please provide your preferred phone number (s) to contact you or leave a message.
Messages will not be left on an unidentified answering machine.

____ Home Number ☐Check if primary contact number

____ Cell Number ☐Check if primary contact number

____ Work Number ☐Check if primary contact number

Medical information typically includes, but not limited to, name of your provider(s), test results, procedures, treatment, and appointments (but not including psychotherapy notes). This may relate to medical information, treatment and any billing information.

Sharing Your Medical Information

Please list who we are authorized to share your (or your minor child's) medical information with.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

I understand that I may revoke this information at any time by sending a written notice to the office. I also understand this authorization includes all communications with clinics and providers affiliated with Mercy.

Signature of patient or legal guardian____

Date____

Relationship if not patient____

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