Mercy Clinics, Inc.

A member of Mercy Medical Center–Des Moines

SCAN TO:
Administrative
→ Alternative Communication

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 is not limited to, name of your provider(s), test results, procedures, treatment, 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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