



Patient Request for Confidential Communication

I, _____, am requesting that Neuroscience Group communicate future information regarding my health care to me in the following manners (check all that apply).

☐ **Primary Telephone** (check one)

- ☐ Leave a message on voicemail and/or with others regarding test results or other health related information.
- ☐ Leave a message with call back number only.
- ☐ DO NOT SPEAK WITH ANYONE BUT MYSELF.

☐ **Work Telephone** (check one)

- ☐ Okay to leave a message on voicemail regarding test results or other health related information.
- ☐ Leave message with callback number only.
- ☐ DO NOT SPEAK WITH ANYONE BUT MYSELF.

☐ **I have someone close to me who may contact Neuroscience Group to discuss my health status, treatment, appointments, and/or payment arrangements.**

I authorize communication with the following person(s).

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Patient Signature

Date of Birth

Neuroscience Group Signature

Date Received