ADULT CONTACT AUTHORIZATION

Name	Date of Birth	MRN / Pt ID Number

CHI Health is committed to protecting our patient's privacy. Please complete the form below to indicate your contact preferences. The permissions and instructions you provide on this form may be accessed and potentially used by any CHI Health entity.

Preferred Contact Method:	**Secondary Contact Method:**
☐ **MyChart (phone contact will be used for urgent messages)**	☐ **MyChart (phone contact will be used for urgent messages)**
☐ **Phone**	☐ **Phone**

Phone: (   ) ______________________________

☐ **Leave detailed message** – lab/test results, medication changes, referral appointment information
- ☐ Voicemail/answering machine
- ☐ Whoever answers the phone
- ☐ You can talk to the following people regarding my care: (list name and relationship)

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OR

☐ **Leave call back message** – provider name/phone number
- ☐ Voicemail/answering machine
- ☐ Whoever answers the phone
- ☐ You can leave a call-back message with the following people: (list name and relationship)

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OR

☐ **Do not leave message** of any kind

Any written communication will go to the address on file. If an alternate address is desired, please complete a "Privacy Practices Action Form – Confidential Communications."	☐ Language Assistance needed Language ______________________

Please sign below to authorize or verify the above contact information. This authorization will remain valid for one year unless revised by you. Changes to this form will require a new form to be completed.

Date	Patient Authorization Signature (or parent or legal guardian) OR Staff verification	Date	Patient Authorization Signature (or parent or legal guardian) OR Staff verification