



**CONTACT AUTHORIZATION**

Name	Chart Number/Pt ID Number	Dates of Service if Applicable
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CHI Health is committed to protecting our patient's privacy. Without authorization, messages left on answering machines, voicemail or with other individuals will be limited to the caller's name, that they are calling for CHI Health and the phone number to call. If you prefer that more complete information be provided, please fill out the form below. This authorization will remain valid for one year unless revised by you. The permissions and instructions you provide on this form may be accessed and potentially used by any CHI Health Ancillary Services entity.

Please contact me as follows:

<p><b>Home/Cell Phone ( )</b> _____</p> <p><input type="checkbox"/> Leave message - appointment date and time</p> <p><input type="checkbox"/> Leave message – provider name/phone number</p> <p><input type="checkbox"/> Leave message - lab/test results, meds. Changes</p> <p><input type="checkbox"/> Do not leave message of any kind</p>	<p>If you have authorized us to leave a message, please indicate specifics below:</p> <p><input type="checkbox"/> Voicemail / answering machine only</p> <p><input type="checkbox"/> Whoever answers the phone</p> <p><input type="checkbox"/> Only the following individuals:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Work Phone ( )</b> _____</p> <p><input type="checkbox"/> Leave message - appointment date and time</p> <p><input type="checkbox"/> Leave message – provider name/phone number</p> <p><input type="checkbox"/> Leave message - lab/test results, meds. Changes</p> <p><input type="checkbox"/> Do not leave message of any kind</p>	<p>E-mail Address _____</p> <p><input type="checkbox"/> Information/Authorization provided, reviewed, and signed.</p> <p>Staff _____ Date _____</p> <p><input type="checkbox"/> Test e-mail completed successfully.</p> <p>Staff _____ Date _____</p>
<p>Any written communication will go to the address on file. Please verify that we have the correct address listed. Any changes: use the Privacy Practices Action Form for Confidential Communications - available on the HIPAA page of MyAlegent</p>	

**CHI Health staff:** Changes in contact information may require system changes and documentation on a Privacy Practices Action Form (PPAF). Forms are available on MyAlegent on the HIPAA page; "Privacy related forms and policies." ***This form does NOT replace those changes.***

**Please sign below to authorize or verify the above contact information. Changes to this form will require a new form to be completed.**

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

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