CONTINUUM
HEALTH CARE

PATIENT COMMUNICATION CONSENT FORM

I agree to allow Continuum Health Care to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize Continuum Health Care to leave messages for me when I am unavailable.

METHOD	NUMBER/ADDRESS	MESSAGES (YES OR NO)
___ Home Phone	(____) _____	☐ Yes ☐ No
___ Cell Phone	(____) _____	☐ Yes ☐ No
___ Work Phone	(____) _____	☐ Yes ☐ No
___ Email	_____@_____	☐ Yes ☐ No

I authorize Continuum Health Care and medical staff to discuss my healthcare information (which may include history, billing, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFO

EMERGENCY CONTACT ONLY-

NAME: _____ PHONE: _____

By my signature below I acknowledge that I have read and understand the **Guidelines to Patient Communication** and information provided on this consent form. I understand the risk associated with the different methods of communication. I consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as may other instruction that Continuum may impose.

Patient Name (Please Print) Date

Patient/Authorization signature Relationship to patient