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PATIENT COMMUNICATION FORM

PLEASE PRINT CLEARLY

PATIENT NAME: ______________________ DATE OF BIRTH: ______________

ADDRESS: ____

We believe that good communication is key to a strong patient - physician relationship. If we send you for a blood test or radiology study we will notify you of the results. Please list the telephone number you would like us to call-in order of preference:

CIRCLE ONE OK TO LEAVE A VOICE MAIL MESSAGE

1) Home / Work / Cell / Fax # ________________________ YES NO

2) Home / Work / Cell / Fax # ________________________ YES NO

3) Home / Work / Cell / Fax # ________________________ YES NO

E-MAIL: ______________________________________

I give permission for the following family members, significant others, etc. to receive information about my test results, referrals, medical condition, etc.

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I understand that on occasion, due to technical problems with mailing, faxing, etc, my provider may not have received my test results when expected. If I have not been notified of my results within 1 week of the test it is my responsibility to telephone the office to follow-up. It is also my responsibility to notify my GIMP physician if I have not been contacted re: planned referrals to other physicians. I understand that I am responsible for notifying this office of any change in the above information.

______________________________ ______________

Signature Date