Yale NewHaven Health
Northeast Medical Group

CONFIDENTIAL COMMUNICATION

_____ _____
Patient Name Date of Birth

Please provide preferred method of communication

I hereby request the following means of communication related to my personal health, treatment, diagnosis, test results or billing as noted below:

I prefer to be contacted by (circle): Home Phone Y / N Cell Phone Y / N Work Phone Y / N US Mail Y / N

I give permission for messages to be left on my voicemail: ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____
3. Name: _____ Relationship: _____ Phone: _____

HIPAA AUTHORIZATION TO DISCLOSE

I give my permission to disclose my personal health information, treatment, diagnosis, test results or billing with:

☐ Check here if you choose the same person(s) as your emergency contact. Please sign and skip to the next section.

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____
3. Name: _____ Relationship: _____ Phone: _____

_____ _____ _____
Patient Signature Printed Name Date

DISCLAIMER

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to NEMG. I understand that a revocation is not effective to the extent that NEMG has relied on the use or disclosure of the protected health information.