COMMUNICATION FORM

Coze Health Medical LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

To our patients: You have the right to request that Coze Health Medical LLC communicate with you by alternative means or at alternate locations. This form instructs Coze Health Medical LLC on your approved communication method and who is involved in your care. By signing this form, you are indicating that your doctor and other staff (nurses, office assistants, etc.) may share limited information with the people named on the form. Limited information will primarily be verbal information but may also include some written or printed information (e.g. care instructions). This form does not grant people names on it the right to obtain access to, or copies of, your health records. If your family member or friend wishes to obtain all or part of your health records, you must authorize their release through our Health Information Management (Medical Records) department. Note: This form will not expire. We will act upon the information you provide on this form unless you inform us that it has changed.

You may contact me via these methods:

__ Call me on my home phone
__ Call me on my mobile phone
__ Email/share documents through non-HIPAA secure account
__ Leave message on home phone
__ Leave message on work phone
__ Leave message on mobile phone

Next of kin (who should we contact in an emergency):

Name	*Relationship*	*Telephone number*
______________________	____________	______________________

Mother's maiden name (for confirmation of identity only): ______________________

I give **consent to receive automated messages** at the phone number listed: ____________________

__ Email reminders and messaging
__ SMS mobile text reminders and messaging
__ Voice reminders and messaging

You may share health information with the following individuals involved in my care:

Name	*Relationship*	*Telephone number*
______________________	____________	______________________
______________________	____________	______________________

Patient Name: ____

Patient Signature ____________________________ *Date* ________________