



PATIENT COMMUNICATION PREFERENCES (Friends & Family Form)

Patient Name: _____ DOB: _____ Account #: _____

Mobile #: _____ Home #: _____ Work #: _____

Emergency Contact Name and #: _____ Other #: _____

Email Address: _____

Preferred Method of Contact: Mobile # Home # Other _____

Account Guarantor: _____ Account #: _____ Relationship: _____

Detailed Message: You may leave a message with medical information on my voicemail/answering machine at the following number(s) (complete all that apply):

Mobile #: _____ Home #: _____

Work #: _____ Other #: _____

Family & Friends: I give my permission for PROS to provide my healthcare information to the following individuals involved in my care:

Name: _____ Relationship: _____ Phone: _____

May leave a message with another member of the household or leave a message on an answering machine.

Name: _____ Relationship: _____ Phone: _____

May leave a message with another member of the household or leave a message on an answering machine.

Name: _____ Relationship: _____ Phone: _____

May leave a message with another member of the household or leave a message on an answering machine.

I acknowledge that I have been presented with a copy of the Notice of Privacy Practices. I understand this form is optional and does not expire. This request will be in effect until I notify PROS of a change:

Signature

Date