DMC PRIMARY CARE
Derry Medical Center

Patient Name: _____

Patient Date of Birth: _____

Communication Preferences and Consent

In order to provide you with medical information and updates in a timely manner, please provide us with your preferences regarding how we may share your information.

Preferred Method of Communication:

☐ FollowMyHealth Portal (to create a FollowMyHealth account, please go to the "FMH Patient Portal" tab on the DMC Primary Care website)

☐ Phone call (provide current phone number): _____

Do we have your permission to leave a detailed message containing clinical information?

☐ Yes ☐ No

Consent for Verbal Communication:

The HIPAA privacy regulations allow us to verbally disclose a patient's health information to a family member, friend, or other person, if the patient agrees. Please list any individual(s) that you authorize DMC Primary care to verbally disclose certain components of your health information.

1. Authorized Representative's Name: _____

Phone Number: _____ Relationship to the patient: _____

2. Authorized Representative's Name: _____

Phone Number: _____ Relationship to the patient: _____

DMC Primary Care may release the following information to the Authorized Representative:

☐ Verify the date and time of my appointments

☐ Discuss clinical information (such as test results, imaging results or medication information)

☐ Discuss information regarding my bill or make a payment on my behalf

I understand that I may revise or revoke this Consent at any time by notifying DMC Primary Care in writing, but if I do, it will not have any effect on actions DMC Primary Care took before it received the updated information.

_____ _____

Patient Signature Date

_____

Relationship to patient (if not the patient)