Patient Means of Communication

I agree that Mosaic Health Center (MHC) can contact me using the following methods regarding my personal health information, evaluation and treatment. I authorize/do not authorize MHC to leave messages for me when I am unavailable as indicated below.

Check to Confirm Approval of Method	Number/Address	Leave Messages
● Home Phone	(_____) _____-_____	● Yes ● No
● Cell Phone	(_____) _____-_____	● Yes ● No
● Text to Cell Phone	(_____) _____-_____	● Yes ● No
● Alternate Phone	(_____) _____-_____	● Yes ● No
● E-mail	_____	● Yes ● No

I authorize MHC to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Phone Number
	_____	(_____) _____-_____
	_____	(_____) _____-_____
	_____	(_____) _____-_____

By my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent Form. I understand the risk associated with different methods of communication, especially email, and consent to the communications outlined in this Consent Form.

Patient Name Printed _____ Date _____

Patient/Authorized Signature ____