



**DETAILED MESSAGE:** You may leave a **message with medical information** on voice mail/answering machine at the following number(s) (complete all that apply):

Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

**FAMILY AND FRIENDS:**

I give my permission for PeaceHealth to give information to the following individuals involved in my care:

Name	Relationship	Phone
<input type="checkbox"/> May leave a message with another member of the household or leave a message on an answering machine.		

Name	Relationship	Phone
<input type="checkbox"/> May leave a message with another member of the household or leave a message on an answering machine.		

Name	Relationship	Phone
<input type="checkbox"/> May leave a message with another member of the household or leave a message on an answering machine.		

**ALTERNATE COMMUNICATION:**

I understand I have the right to request that PeaceHealth communicate with me by alternative means or at alternate locations. We will accommodate all reasonable requests. All e-mail will be sent through your **My PeaceHealth** account.

I wish to receive communication of my Protected Health Information from PeaceHealth by the following means: \_\_\_\_\_

I acknowledge that I have been presented with a copy of the Detailed Message & Patient Communication Preferences information sheet. I understand this form is optional and does not expire. This request will be in effect until you notify PeaceHealth of a change.

Signature Patient/Person Authorized to Sign for Patient - Relationship \_\_\_\_\_ Date Time \_\_\_\_\_

Printed Name \_\_\_\_\_

SYS1068 (02/03/16)

Patient Identification



Alt Communication

**To our patients:**

You have the right to request that PeaceHealth communicate with you by alternative means or at alternate locations. Please use the attached form to tell us how you prefer to communicate with us.

You may also use this form to tell PeaceHealth who is involved in your care so that we can provide them with the information they need to assist you. If you choose to identify the individuals who are involved in your care on this form, you should be aware of the following:

- By completing and signing this form, you are indicating that your doctor and other staff (nurses, office assistants, etc.) may leave a detailed message regarding your healthcare and share limited information with the people named on the form.
- This form is completely optional. You are **NOT** required to complete it in order for us to share limited information with people involved in your care, unless you object.
- Information shared with the people named on this form will be limited to what they need to know to assist with your care at home and elsewhere. This will primarily be verbal information but may also include some written or printed information (e.g. care instructions).
- This form will not expire. We will act upon the information you provide on this form unless you inform us that it has changed.
- **This form is not a legal authorization, consent, release, or agreement.**
- This form does **NOT** grant the people named 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.

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SYS1068 (02/03/16)

Patient Identification

PeaceHealth  
**Detailed Message and Patient Communication  
Preferences**

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