Cedar Valley Medical Specialists, P.C.
We specialize in you.

Cedar Valley Medical Specialists, P.C.
Patient Communication Form for Privacy Practices

Our office will make an effort to notify you of your test/lab/procedure/etc. results, if necessary. You may instruct Cedar Valley Medical Specialists, P.C. as to the method of communication and who may and/or may not receive these communications.

Please Mark the Best Method of Communication

☐ Home Phone (____) _____

☐ Cell Phone (____) _____

☐ Work Phone (____) _____

☐ Mailing Address _____

_____

_____

☐ Email Address _____

I give my permission for the following **TO RECEIVE** my Personal Health Information if necessary.

(Optional)

Spouse (full name) _____ (Phone) _____

Child (full name) _____ (Phone) _____

Friend (full name) _____ (Phone) _____

Parent (full name) _____ (Phone) _____

Other (full name) _____ (Phone) _____

DO NOT give my personal Health Information to the following named person/persons.

(full name) _____ (Phone) _____

(full name) _____ (Phone) _____

I hereby acknowledge that I have been informed, that I may receive a copy of Cedar Valley Medical Specialists, P.C.'s Notice of Privacy Practices upon request.

☐ **Copy Provided** ☐ **I do not want a copy**

_____ _____

Patient's Signature and/or Guardian **Date**

_____ _____

Printed Name **Date of Birth**

_____

Guardian's relationship to patient