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PATIENT REQUEST FOR CONFIDENTIAL CHANNELS OF COMMUNICATION

Patient Name: _____ Date of Birth: _____

I understand that when Dr. A. Reza Moattari must contact me regarding my appointment or for any other reason, he will contact me by telephone or by mail.

I hereby request to receive communication as follows:

1. By Telephone (please check all that apply)
   - ? At Home Telephone Number _____
   - ? At Work Telephone Number _____
   - ? Cell Phone Telephone Number _____
   - ? Other Telephone Number _____

   When providing information by telephone, I hereby consent to the following:
   - ? Leave message on my voicemail/answering machine for appointment reminder.
   - ? Leave message on my voicemail/answering machine to call office back.
   - ? Leave message on my voicemail/answering machine providing test/procedure information or results.
   - ? Leave message with another person at this number for appointment reminder.
   - ? Leave message with a nother person at this number to call our office back.
   - ? Leave message with the following person(s) providing test/procedures information or results.

     Name of person and relationship to patient.
     1. _____
     2. _____
     3. _____

2. By Mail
   - ? At my home address: _____
   - ? At my business address: _____
   - ? Other address: _____

   By Fax
   - ? Fax Number _____

I certify that I am the patient's personal representative and am authorized to sign this form.

Print Name: _____ Signature: _____
Date: _____ Relationship to Patient: _____
If patients personal representative, attach a copy of legal authority.