

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

I give permission to be contacted at the following phone number(s) regarding messages, appointments, and/or personal health information for myself, or my minor children, unless restricted by state and/or federal regulations.

Primary phone number for appointment reminder calls: _____

Other phone numbers I may be contacted at:

Home: _____ OK to leave a message? Yes No

Cell: _____ OK to leave a message? Yes No

Work: _____ OK to leave a message? Yes No

Fax: _____

Other: _____ OK to leave a message? Yes No

The following person(s) have my permission to act as my designated health care representative. They may communicate verbally, and in writing, with Des Moines University Clinic staff about my personal health information. *This information may include medical information, financial and insurance information, HIV, drug and alcohol, and/or mental health information.*

Name: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to patient: _____

Name: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to patient: _____

I hereby authorize Des Moines University Clinic to communicate my personal health information as stated above. *This information may include medical information, financial and insurance information, HIV, drug and alcohol, and/or mental health information.*

Disclaimer: I understand that DMU Clinic cannot guarantee confidentiality of information shared with the person(s) listed above, or when leaving a message at a phone number listed above.

I understand that this permission will be valid until I revoke this in writing.

Signature of patient or legal representative

Date

Relationship to patient if not signed by patient

For DMU Staff Only

Medical Record Number: _____