Mercy Clinics, Inc.
A member of Mercy Medical Center–Des Moines

SCAN TO:
Administrative
→ Alternative Communication

Confidential Alternative Communications Request

Patient_____ Date of Birth _____

Contacting You About Your Medical Information

We may need to contact you about your (or your minor child's) medical information. Please provide your preferred phone number(s) to contact you or leave a message. Messages will not be left on an unidentified answering machine.

Home number_____ ❑ Check if primary contact number

Cell number_____ ❑ Check if primary contact number

Work number_____ ❑ Check if primary contact number

Medical information typically includes, but is not limited to, name of your provider(s), test results, procedures, treatment, appointments (but not including psychotherapy notes). This may relate to medical information, treatment and any billing information.

Sharing Your Medical Information

Please list who we are authorized to share your (or your minor child's) medical information with.

Name_____Relationship_____Phone _____

Name_____Relationship_____Phone _____

Name_____Relationship_____Phone _____

I understand that I may revoke this information at any time by sending a written notice to the office. I also understand this authorization includes all communications with clinics and providers affiliated with Mercy.

Signature of patient or legal guardian_____ Date_____

Relationship if not patient_____

1019-139-W 09/20/13