INTERMED
Care without compromise.

Patient Communication Form

Patient's Legal Name: _____ **Date of Birth:** _____
First MI Last

Parent(s)/Legal Guardian(s): _____

Mailing Address: _____

E-mail Address: _____

By providing my email address I understand I will remain/be enrolled in a MyInterMed patient portal account. This service is offered to adult patients 18 years of age and older.
Check this box if you do NOT want to be enrolled in the patient portal. ☐

Phone Contacts	**Circle One**	**Circle One**
(____) _____ ☐ Home ☐ Cell ☐ Work	Okay to leave message? Yes/No	**Extended Message? Yes/No
(____) _____ ☐ Home ☐ Cell ☐ Work	Okay to leave message? Yes/No	**Extended Message? Yes/No

***Extended messages may contain medical and/or prescription information.*

I agree to receive follow up surveys by an automated dialing service and/or an artificial or prerecorded voice, and/or text messages to my telephone number or cell phone number provided during my registration process.
Check this box if you do NOT want to receive follow up surveys via cell phone. ☐

Patient's Marital Status (Circle One) Single Married Partner Divorced Widowed

Patient's Primary Care Physician: _____

Patient's Employer: _____ **Occupation:** _____

Patient's Health Insurance Company: _____ **Policy Number:** _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Telephone: Cell (____) _____ Home (____) _____ Work (___) _____

Select One:

☐ **I do <u>not</u> want any information about my healthcare communicated to family members/caregivers.**

☐ **I give InterMed permission to verbally communicate to family members/caregivers listed below.**

Name:_____ **Name:**_____ **Name:**_____

Please check the box next to the specific information that may be **<u>verbally</u>** communicated to the individual(s) listed above:

☐ Prescription Request ☐ Request/Confirm/Cancel Appointments ☐ Referral Request

This authorization will be updated every 12 months. I have the right to revoke this authorization in writing at any time. Revocation will not cover information released prior to that date. If I want to grant permission to InterMed to discuss other information, including AIDS/HIV, Alcohol and/or Drug Abuse, or Mental Health with anyone besides myself, I understand that I will need to complete a separate *Release of Information* form.

Patient/Parent/Legal Guardian Signature Date

<u>Office Use Only</u>
☐Data entered into eCW ☐ Insurance card scanned ☐Driver's license/picture ID scanned

Updated: 12.2015