

Patient Sticker Here

Baylor Regional Medical Center Grapevine

**PATIENT HEALTH INFORMATION REQUEST FORM**

At which of the following number(s) do we have permission to contact you?

- Home \_\_\_\_\_  
 Cell \_\_\_\_\_  
 Work \_\_\_\_\_  
 Other \_\_\_\_\_

May we leave a message for you at work?

- Yes  No

May we leave a message for you at home?

- Yes  No

Other than you, whom may we talk to about your healthcare information?

- Spouse Name/Telephone \_\_\_\_\_  
 Caretaker Name/Telephone \_\_\_\_\_  
 Child Name/Telephone \_\_\_\_\_  
 Parent Name/Telephone \_\_\_\_\_  
 Other Name/Telephone \_\_\_\_\_

*\*Please indicate phone number where an approved contact may be reached during surgery*

\_\_\_\_\_

Do you have any health information that you would like kept confidential from any person or persons?

- Yes  No

If so, please describe below:

\_\_\_\_\_

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient

\*\*Not Permanent Part of Record

