



Patient Contact Form

Patient _____ Date _____

All calls regarding your care, test results and appointments will be made to the telephone number as indicated here: () _____ .

Appointment reminders can be voice and/or text messages. Please indicate preference. (OHHS is not responsible for any charges that may apply to text messages).

____ voice message

____ text message (must be cell phone for text messages: cell # _____)

____ I opt out of appointment reminders

Please check one:

_____ I hereby authorize Ohio Hills Health Services to contact me by telephone and if I am not present, they may leave a voice mail.

_____ DO NOT leave messages on voice mail other than the name of who called and the telephone number.

Other contact information

The following people other than a guardian or conservator are authorized to discuss my medical condition and/or billing information with a healthcare professional at Ohio Hills Health Services

Name	Relationship	Phone Number
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Name	Relationship	Phone Number
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Patient Signature

Date