Patient Contact Form

Patient_____ Date_____

All calls regarding your care, test results and appointments will be made to the telephone number as indicated here: ( )_____ (must be cell for text messages, see below).

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

____ 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
Name	Relationship	Phone Number

_____

Patient Signature Date