



1st Review: _____
2nd Review: _____
3rd Review: _____

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

Name Relationship Phone Number

Patient Signature Date