OBGYN Obstetrical & Gynecological Associates of Des Moines p.l.c.

Confidential Alternative Communications Form

Patient Name: _____ **Date of Birth:** _____

(Please Print)

Please list the numbers we may use to contact you:

☐ I give my permission to leave a message/results on an answering machine. (*medical information will not be left on an unidentified answering machine*)

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Emergency Contact:

Name	Phone	Relationship
_____	_____	_____

Release of Information:

Any information regarding appointment dates, times or financial information on my account may be given to:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

Any medical information may be given to:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

I prefer **no information** be given to anyone other than me _____ (initial)

This form of communication will be used until revoked in writing by the patient, by expiration date below, or we have an updated form on file. Patient must initial below for the form to be valid. Please email the completed form to transcription@obgyndm.com.

Patient Signature: _____ Date: _____

Relationship if not patient: _____

Effective Date: _____ Expire Date: _____ **Patient Initials**: _____