Wayne Memorial Hospital
Honesdale, PA 18431
Urology

PATIENT CONTACT PREFERENCES

PATIENT NAME: _____ Date of Birth: _____

In general, ***the*** HIPAA PRIVACY RULE permits WMH to communicate with our patients regarding their health care. This includes communicating with our patients at their homes, whether through the mail or by phone or in some other manner. In addition, the Rule does not prohibit WMH from leaving messages for patients on their answering machines. Please select your preferences below. WMH recognizes our patients' right to request a restriction on uses and disclosures of their protected health information (PHI). Patients can request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Please note any preferences below.

In an effort to protect our patients' privacy, before discussing your health information with those involved in your care, we may ask your permission and give you an opportunity to object; or we may decide, using our professional judgment, that you do not object. In any of these cases, your health care provider may discuss only the information that the person involved needs to know about your care or payment for your care.

Select all of the ways we ***may*** communicate with you:

- ☐ **Home Telephone** _____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave a message with a call back number only
- ☐ **Cell Phone**_____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave a message with a call back number only
- ☐ **Work Telephone** _____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave a message with a call back number only
- ☐ **Mail**
  - ☐ OK to mail to my home address
  - ☐ OK to send email to my email address
- ☐ ***Other*** _____

Please indicate the preferred way to reach you:
(select one)

- ☐ **CELL**
- ☐ **HOME PHONE**
- ☐ **WORK PHONE**
- ☐ **EMAIL**

Please provide your preferred email address:

_____
EMAIL ADDRESS

☐ **No Email**

Next of Kin Name: _____ Relationship: _____
Best number to reach this person: _____

Guardian/Authorized Rep. Name: _____ Relationship: _____
Best number to reach this person: _____

Alternate Contact's Name:_____ Relationship: _____
Best number to reach this person: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I acknowledge that I have received the Notice of Privacy Practices for Wayne Memorial Hospital. I have been given an opportunity to ask any questions regarding the privacy notice that I may have at this time, and agree to have my health information disclosed (as necessary) as indicated above. I am also aware that I may contact the privacy officer at 570-253-8278 if I have any further questions.

Patient Signature: _____ Date _____
Guardian/Authorized Rep. Signature: _____ Date _____
Print Guardian/Authorized Rep. Name: _____