Methodist
DALLAS MEDICAL CENTER

Golden Cross
Academic Clinic
122 West Colorado Blvd.
Dallas, Texas 75208
214.947.6700
214.947.6701 *fax*

CONTACT PERMISSION FORM

Patient Name:_____

Golden Cross Academic Clinic ("GCAC") may need to use your name, phone number, email address ("Contact Information"), and your clinical records to contact you with information about your healthcare treatment. If this communication is made by phone and you are not available, a message will be left on your voice mail or with the person answering the phone. By signing this form, you are consenting for GCAC to contact you with information and to leave messages on a voice mail or with individuals who answer the phone.

Information that we use or disclose based on this consent may be subject to re-disclosure by anyone who has access to the reminder and may no longer be protected by federal privacy rules.

You have the right to refuse to give GCAC your consent to use your telephone number and/or email address. If you choose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give GCAC this consent or revoke it in the future, it will not affect the treatment we provide to you.

My preferred method of communication regarding my **health information** is indicated below **(please list in order of your preference):**

[ ] Home phone [ ] Work phone [ ] Cell phone

[ ] Mailed letter [ ] E-Mail [ ] Other:_____

Please indicate your top two to three preferred methods of communication. For example, if your home phone is your top preference and cell phone is your second preferred method, place a "1" in the box by home phone and a "2" in the box by cell phone.

Keeping our patient's health information private is important to us. We will only disclose information related to your **Billing Account** and **Health Information** to you or your **Legal Guardian.**

If you would like to add additional individuals that GCAC is allowed to disclose this type of information to, please complete the fields below and select the appropriate boxes based on your approval for each person that you list. In addition, please choose the person you would like GCAC to list as your **Emergency Contact** in the event an emergency situation was to take place at GCAC.

_____ _____ _____
Contact Name Relationship to Patient Contact Phone Number

[ ] Billing Account Information [ ] Medical Condition Information [ ] Emergency Contact

_____ _____ _____
Contact Name Relationship to Patient Contact Phone Number

[ ] Billing Account Information [ ] Medical Condition Information [ ] Emergency Contact

I understand that it is my responsibility to notify GCAC of any changes in my Contact Information and I understand that there shall be no liability on GCAC's part should I forget to do so. Unless I otherwise revoke my consent, this consent will expire one year after the date of my last service or treatment with GCAC.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

I acknowledge that I have received a copy of this consent but DECLINE to give GCAC consent to use my Contact Information and clinical records to contact me with information about my health care treatment.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**