

**COLORECTAL PHYSICIANS & SURGEONS OF PENNSYLVANIA**

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**Colorectal Physicians & Surgeons of Pennsylvania**  
**Personal Communication of Your Patient Information**

**NAME** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

There may be times when we would like to informally contact you with information, or when you may want us to tell others, such as family or friends, about your condition or treatment. For instance, we may need to contact you to report test results or you may want us to inform your family of how your treatment is proceeding. We refer to this type of informal communication as "Personal Communication." Please fill out this form to help guide us in providing Personal Communications about you.

1. Please indicate who else (if anybody) we may communicate with concerning your condition and/or treatment?  
 No one  
 My Spouse, please name: \_\_\_\_\_  
 My Children please name: \_\_\_\_\_  
 My Parent(s) please name: \_\_\_\_\_  
 Others: \_\_\_\_\_

2. May we provide Personal Communication to you by telephone?  
 Yes  No

If yes, please list the telephone number we may use, if it is other than what we currently have on file:  
\_\_\_\_\_.

3. If you are not available when we call by telephone, may we provide the information to the person who answers, or leave the information on an answering machine?  
 Yes  No

4. If we use regular mail to provide Personal Communication to you we will use the address you have given us. If you want us to use an address different than what we have on file, please list it here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. If there are any other specific requests for restriction on Personal Communication that you would like to make, please note them here:

\_\_\_\_\_  
\_\_\_\_\_

6. This form will remain in effect for the following term:  
 As long as I am a patient  This treatment & follow-up only  Other: \_\_\_\_\_

I understand the following with respect to this form:

- I may refuse to complete/sign this form. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- If the person(s) receiving information about me through Personal Communication is not a health care provider or a health plan covered by Federal Privacy Regulations, the information may be redisclosed and no longer protected by Federal Privacy Regulations.
- I may change or revoke this form in writing at anytime, for future Personal Communications.
- If Saint Vincent is able to agree to this request, it will supercede any previous made for this patient. Saint Vincent will notify you if unable to agree to any section of this request.

\_\_\_\_\_  
Signature of patient or patient's legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print patient's name

\_\_\_\_\_  
Print name of legal representative (if applicable)

\_\_\_\_\_  
Relationship to patient