Communication Preference and Confidentiality Form

At Redrose Medical, your comfort and confidence in our communication are paramount. We kindly request that you specify your preferred method of contact below (email, phone, fax, etc.) for any healthcare-related discussions or updates:

- **Preferred Method of Contact:**
- **Additional Notes:**

Designated Contacts for Health Information

(Optional) For enhanced personalized care and with your consent, we encourage you to list any individuals with whom we are authorized to share your health information. Please include each person's relationship to you. You may update this list at any time:

- **Authorized Contact(s):**

Restrictions on Health Information Disclosure

(Optional) Should there be any individuals or entities to whom you expressly **do not** wish your personal health information to be disclosed, kindly list them below:

- **Do Not Disclose To:**

Insurance and Billing Information

To facilitate seamless coordination with laboratories and other providers for billing purposes, please provide your insurance information:

- **Insurance Company Name:**
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- **Insured Name:**
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- **Insured’s Date of Birth (DOB):**
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- **Policy ID#:**
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Emergency Contact Details

In the event that we are unable to reach you directly, please provide an emergency contact:

- **Emergency Contact Name:**
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- **Contact Information:**
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Privacy Practices Acknowledgment

I affirm that I have been acquainted with Redrose Medical's Notice of Privacy Practices, available for review in the waiting area. I understand my entitlement to a copy of this notice upon request and hereby authorize the disbursement of medical benefits to Redrose Medical for any services rendered. I also consent to the release of medical records or other information necessary for the processing of claims related to medical services rendered to me.

- **Patient Signature:** **Date:**
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- **Print Name:** **Date of Birth:**