

# BELLINGHAM OB/GYN

## Communication Preferences

Please select your preferred contact method for the following services. CHECK ALL THAT APPLY

### Health Notifications

We will notify you when your lab results and health reminders are available on the Patient Portal. Your results will not be disclosed.

Email                       Phone                       Text

### Appointment Reminders

We will contact you to remind you about scheduled appointments

Email                       Phone                       Text

### Updates and Announcements

We will notify you regarding appointment cancellations/recommendations, weather events and other important announcements.

Email                       Phone                       Text

### Billing

We will contact you when new billing statements are available. You can view your billing statement and make payments on the Patient Portal. If necessary, we will notify you if a balance is past due.

Email                       Phone                       Text

## Phone Message Consent

We will always attempt to contact you by your preferred method. However, when necessary we may need to contact you by phone to provide updated or detailed information regarding your care. Please select if you would like us to be able to leave you a detailed message.

I authorize Bellingham OBGYN to leave a detailed message at the following number:

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## Social Media

I give Bellingham OB/GYN permission to use photos of myself and/or children for social media purposes

Yes                       No

## Consent to Release Information to Authorized Contacts

In accordance with our privacy practices, we will only release information to other individuals with your consent. An authorized contact is not an Emergency Contact. If you have already designated someone as an Emergency Contact, you will still need to provide your consent for them to be an Authorized Contact.

I authorize Bellingham OBGYN to disclose and discuss my protected health information with

Name(s): \_\_\_\_\_

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## HIPAA Declaration

I acknowledge that I have had the opportunity to review a copy of the Bellingham OBGYN Privacy Practices Notice. I understand that I am responsible to read this Notice and notify Bellingham OBGYN, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information.

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Patient Signature

Date