VITAL CARE

CONTACT AND COMMUNICATION INFORMATION FORM
PHI, SIGNATURE, AND DELIVERY AUTHORIZATION FORM

PATIENT INFORMATION

Name			
	First Name	Last Name	Patient ID Number

CONTACT INFORMATION – AUTHORIZATON TO LEAVE INFORMATION

Indicate below the methods by which our pharmacy can communicate information to you about your treatment or services.

Method	May Contact?	If Yes, Provide Contact Information	Order of Contact Preference	Additional Permissions	Patient Initials
Home Phone	No Yes	( ) -	1 2 3 4	May leave voicemail	_____
Cellular Phone	No Yes	( ) -	1 2 3 4	May leave voicemail May text	_____
Work Phone	No Yes	( ) -	1 2 3 4	May leave message	_____
E-mail Address*	No Yes	@ .com	1 2 3 4	*Will only be used to coordinate care/services	_____

EMERGENCY CONTACT INFORMATION

*If the pharmacy is unable to reach you at the information provided above, indicate below the method by which we may communicate information to you. Please provide individuals with contact information **different** than that provided above.*

Name	Relation	Emergency Contact Number (MUST be a different number than provided above)	Order of Contact Preference
		( ) -	1 2
		( ) -	1 2

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Indicate below the names of individuals with whom we may discuss your treatment and services.

Name	Relation	Patient Initials
I understand that by requesting confidential communication that I may restrict the use and disclosure of my PHI to individuals that may otherwise be for my benefit. I understand that I am responsible if the information I provided is incorrect, or if the information later changes and I fail to report the change. Any changes made in the authorization or restriction of PHI must be provided in writing.		_____
		_____
		_____

SIGNATURE AUTHORITY

Indicate below the names of third parties that have been given authority by the patient to sign on his/her behalf, and the reason.

Name of Third Party	Relation	Reason	Patient Initials
			_____
			_____

AUTHORIZATION TO ACCEPT DELIVERY OF MEDICATION, EQUIPMENT, AND/OR SUPPLIES

Indicate below the names of individuals that may accept deliveries on your behalf.

Name	Relation	Patient Initials
		_____
		_____

Patient Signature		Patient Initials		Date	