Health Department & Community Health Center

WILL COUNTY COMMUNITY HEALTH CENTER
CONSENT TO CONTACT PATIENT FORM

PATIENT NAME: _____ **Date of Birth:** _____

I wish to be contacted in the following manner (check all that apply)

☐ **Home Telephone**_____

☐ Leave message with detailed information

☐ Leave message with call-back number only

☐ Leave Message that "Grace" called. Use code name: Grace (to inform you that WCCHC called)

☐ **Work Telephone**_____

☐ Leave message with detailed information

☐ Leave message with call-back number only

☐ Leave Message that "Grace" called. Use code name: Grace (to inform you that WCCHC called)

☐ **Cell phone number**_____

☐ Leave message with detailed information

☐ Leave message with call-back number only

☐ Leave Message that "Grace" called. Use code name: Grace (to inform you that WCCHC called)

Written Communication (we must have a way to contact you in writing if necessary)

Select one:

☐ Mail to my home address: _____

☐ Mail to my work/office address: _____

☐ Mail to my email address: _____

I give permission to the Will County Community Health Center Providers and staff to discuss my information with:

Name_____ Relationship_____

Name_____ Relationship_____

☐ Unrestricted information regarding my health care

☐ Unrestricted information regarding my billing and insurance

☐ My health care and billing/insurance information with the following restrictions (e.g. Behavioral Health Information, STD):

_____

_____

_____

In case of emergency, contact:

Name: _____ Relationship: _____
Telephone: _____ Cell Phone No.: _____

Patient Signature_____ Date_____

Authorization will remain in effect until patient's written request is received to cancel.