



CROSSWOODS  
WOMEN'S HEALTH

**Protected Health Information (PHI)**

Patient Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please list any individual with whom we may share your protected health information (PHI)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Contact ( ) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Contact ( ) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Contact ( ) \_\_\_\_\_

There are times we need to call and give you test results. If we receive a voicemail, is it okay to leave a detailed message?

YES	NO
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At what number may we leave this detailed message?

Contact ( ) \_\_\_\_\_

HOME	CELL	WORK
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Patient Signature \_\_\_\_\_