☐ **Plaza Medical Centre**
700 N Pearl St, Suite N208
Dallas, TX 75201
Tel: (214) 999-9355


☐ **Griego Family Medical Centre**
2701 S Hampton Rd, Suite 101
Dallas, TX 75224
Tel: (214) 330-9221

# COMMUNICATING WITH YOU

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your provider's office. **We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail.**

Please check all boxes that you give Metroplex Medical Centres permission to use for your communications:

☐ You may contact me by telephone Phone Number: _____

☐ You may leave a message/voice mail Phone Number: _____

☐ You may contact me by mail

☐ You may contact me through email Email Address: _____

If you give permission for us to communicate with anyone else, please complete the list below:

| | Name | Relationship | Phone Number | Options |
|---|---|---|---|---|
| 1. | | | | ☐ Billing Information<br>☐ Appointment Information<br>☐ Medical/Health Information |
| 2. | | | | ☐ Billing Information<br>☐ Appointment Information<br>☐ Medical/Health Information |
| 3. | | | | ☐ Billing Information<br>☐ Appointment Information<br>☐ Medical/Health Information |

This request supersedes any prior request for communication of information I may have made.

_____ _____
**Signature of Patient/Responsible Party** **Date**

_____ _____
**Name of Patient/Responsible Party (Print)** **Relationship to Patient**

**Preferred Pharmacy**

**Pharmacy Name:** _____ **Phone:#** _____

**Pharmacy Address:** _____