FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

PATIENT COMMUNICATION INSTRUCTIONS

Patient Name: _____ **Date of Birth:** _____

I hereby give my consent for Dr. Lee and the staff at the Family Fertility Center to contact me at the following phone number(s).

Phone # 1_____ □ home □ work □ cell □ other _____

☐ yes ☐ no, do not leave a message such as "Please call Dr. Lee's office"

☐ yes ☐ no, do not leave on the voice mail or answering machine full details regarding my personal health information including but not limited to test results, medications, and other instructions.

☐ yes ☐ no, do not leave full details regarding my personal health information including but not limited to test results, medications, and other instructions with the following individual(s)

(name(s) of person and relationship) _____

****

Phone # 2_____ □ home □ work □ cell □ other _____

☐ yes ☐ no, do not leave a message such as "Please call Dr. Lee's office"

☐ yes ☐ no, do not leave on the voice mail or answering machine full details regarding my personal health information including but not limited to test results, medications, and other instructions.

☐ yes ☐ no, do not leave full details regarding my personal health information including but not limited to test results, medications, and other instructions with the following individual(s)

(name(s) of person and relationship) _____

****

Phone # 3_____ □ home □ work □ cell □ other _____

☐ yes ☐ no, do not leave a message such as "Please call Dr. Lee's office"

☐ yes ☐ no, do not leave on the voice mail or answering machine full details regarding my personal health information including but not limited to test results, medications, and other instructions.

☐ yes ☐ no, do not leave full details regarding my personal health information including but not limited to test results, medications, and other instructions with the following individual(s)

(name(s) of person and relationship) _____

****

Other Special Communication Instructions _____

_____

Patient Signature: _____ **Date:** _____