DOCTOR ATTEMPT TO CONTACT LETTER

Patient Name: _____

Provider Information:

Doctor Name: _____

Practice Address: _____

Phone Number: _____

Attempt to Contact Details:

This letter documents the reasonable attempts made by the undersigned healthcare provider or their authorized representative to contact the patient or the patient's authorized representative regarding important health information and/or follow-up care. Multiple attempts have been made using the contact information provided by the patient, including but not limited to telephone calls, voicemails, and written correspondence.

Details of Contact Attempts:

Date(s) and Time(s) of Attempt(s): _____ Method(s) of Contact Attempted: _____ Outcome/Notes:

_____

Purpose of Contact:

The purpose of these attempts is to ensure the patient receives timely and appropriate medical care, to discuss test results, to provide necessary health education, or to arrange follow-up appointments as clinically indicated.

Patient Responsibility:

The patient or authorized representative is responsible for maintaining current and accurate contact information with the provider. Failure to respond or update contact details may impact the continuity of care. This letter serves as a formal record of the provider’s diligence in attempting to reach the patient.

Legal Notice:

This document serves as verification of the provider’s good faith effort to communicate with the patient. All information contained herein is maintained in accordance with applicable federal and state laws, including HIPAA privacy regulations. The provider’s attempts to contact the patient do not constitute abandonment of care unless otherwise specified in writing.

Acknowledgement:

By signing below, the undersigned certifies that the above information is accurate and complete to the best of their knowledge, and that appropriate attempts were made to contact the patient or their authorized representative.

Provider Signature:

Signature: _____

Name (Printed): _____

Date: _____

Title/Role: _____

Patient/Authorized Representative Signature:

Signature: _____

Name (Printed): _____

Date: _____

Relationship to Patient: _____