Bluegrass Community Health Center

PATIENT CONFIDENTIAL COMMUNICATIONS

In order to protect your privacy, we ask that you complete this form so we know the ways in which we may communicate with you regarding your health information. Please mark as many of the communication options below you feel comfortable with so we have multiple ways to reach you regarding important matters concerning your health care.

Patient First Name	Last Name	Middle	Patient Date of Birth:

I prefer to receive my appointment reminders in the following method: *Please note text message rates may apply.*
☐ Phone Call Phone Number:_____ ☐ Text message Cell Phone Number:_____

I authorize BCHC, its providers, and employees, to do the following:

☐ Yes ☐ No	Leave a message at my home/cell number regarding appointment reminders/scheduling. ***It is important that you always keep your home/cell number updated with BCHC.***
☐ Yes ☐ No	Send my appointment reminders in a text message.
☐ Yes ☐ No	Send me a letter in the mail regarding appointment reminders, test results and/or scheduling needs.
☐ Yes ☐ No	Leave my test results in a message at my home/cell number.
If you would like to receive your health information in another way or in another format, please indicate it below:	

I authorize BCHC to discuss my health care as indicated with following individuals:

Name 1:	Relationship to patient:	Phone Number:
☐ Appointment Date, Time, and Location ☐ Billing Information ☐ Prescription Information (including picking up prescriptions) ☐ All Medical Information- except HIV test results, drug, alcohol, or mental health treatment records and information regarding pregnancy or STDs	☐ Yes ☐ No I authorize the release of information regarding pregnancy, STD testing and treatment to the person listed above. ☐ Yes ☐ No I authorize the release of my HIV status, whether negative or positive, to the person listed above. ☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person listed above.	Dates of Information to be disclosed: ☐ No Date Restrictions ☐ Specific Dates: From:_____ To:_____
Name 2:	Relationship to patient:	Phone Number:
☐ Appointment Date, Time, and Location ☐ Billing Information ☐ Prescription Information (including picking up prescriptions) ☐ All Medical Information- except HIV test results, drug, alcohol, or mental health treatment records and information regarding pregnancy or STDs	☐ Yes ☐ No I authorize the release of information regarding pregnancy, STD testing and treatment to the person listed above. ☐ Yes ☐ No I authorize the release of my HIV status, whether negative or positive, to the person listed above. ☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person listed above.	Dates of Information to be disclosed: ☐ No Date Restrictions ☐ Specific Dates: From:_____ To:_____
The person(s) listed above will be notified that I must give specific written permission before disclosure of HIV test results, drugs, alcohol, or mental health treatment records or information regarding pregnancy or STDs to anyone.		

I understand that I have the right to change or cancel this request at any time by completing a new form. I also understand that the changes or cancellation will not affect action taken based on this request prior to the change or cancellation. The form will be updated annually.

_____ _____ _____
Signature of Patient — Printed Name — Date
If patient is under 18 years of age, responsible party/guarantor signature

_____
Relationship to Patient

Account Number:

Updated: February 2020