Foothills Health and Wellness Center
108 12th Street
Clay City, KY 40312

Confidential Communications

In order to protect your privacy, we ask that you complete this form so we can 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 Name: _____ Date of Birth: _____SSN:_____

I, _____ authorize Foothills Health & Wellness Center, its Providers and employees, to do the following:

(PLEASE CHECK THE OPTIONS YOU PREFER)

_____ Leave a message at my home/cell number.

_____ Call me at work and/or leave a message. Work phone number:_____

_____ Contact me by mail.

_____ Leave test results on my answering machine.

_____ Leave appointment reminders on my answering machine.

_____ Give results to and/or disclose my healthcare/insurance/billing with:

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

Other: _____

I understand that I have the right to change or cancel this request at any time by notifying the Medical Office Manager, in writing, at KRFDC, Attn: Medical Office Manager, 108 12th Street, Clay City, KY 40312. I also understand that the changes or cancellation will not affect action taken based on this request prior to the changes or cancellation.

_____ _____

Patient Signature or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Witness Date