Foothills Health & Wellness Center

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 communications options below you feel comfortable with so we have multiple ways to reach you regarding important matters concerning your healthcare.

Patient Name: _____ Date of Birth: _____

I, _____ authorize *Foothills Health & Wellness Center* , it's 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.

_____ Contact me by e-mail address: _____@_____

_____ 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: _____ Phone: _____

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 FHWC, Attn: Angela Judd, 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**

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