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 Name: _____ Date of Birth: __ __ / __ __ / __ __ __ __

I prefer to receive my appointment reminders in the following method: ☐ Text message ☐ Phone call

I authorize White House Clinics, 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 White House Clinics***
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.
Yes No	Send my appointment reminders in a text message.

I authorize White House Clinics to discuss my healthcare as indicated with the following individuals:

Name:	**Relationship:**	**Phone:**
Give the following information to this individual (circle all that apply): Appointment Reminders Test Results Billing Information		
Name:	**Relationship:**	**Phone:**
Give the following information to this individual (circle all that apply): Appointment Reminders Test Results Billing Information		

If applicable, minor children's immunization records and/or school excuses may be released as needed to the following schools and/or daycares if applicable: _____

White House Clinics conducts periodic patient satisfaction surveys. Survey respondents are chosen at random. If you are chosen to receive the survey, you will receive a text message to share your opinion regarding your recent experience at our clinic. Please note text message rates may apply.

Yes No	I would like to participate in White House Clinics Patient Satisfaction Survey. I consent to receiving text messages regarding my recent experience.

I understand that I have the right to change or cancel this request at any time by notifying the Privacy Officer, in writing, at Health Help Inc., Attention: Privacy Officer, 401 Highland Park Dr., Richmond, KY 40475. I also understand that the changes or cancellation will not affect action taken based on this request prior to the change or cancellation.

_____ _____

Signature of Patient/Representative and Date Printed Name of Patient/Representative

_____ _____

Relationship to Patient Witness Signature and Date

Expiration: To be updated yearly. *Updated June 2018*