BOONE COUNTY HOSPITAL CLINICS

Communication Request

Please Print Name: ____ Date of Birth: __________________

In order to effectively communicate with you (or your minor child) about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. We may communicate with you through mail, secure email, and telephone including leaving messages on your answering machine/voice mail.

Please check all boxes that you give Boone County Hospital Clinics permission to use for your communication.

- ☐ You may contact me by telephone. Phone Number: ____________________________
- ☐ You may leave a message/voice mail. Phone Number: ______________________________
- ☐ You may contact me by mail.
- ☐ You may contact me through Patient Portal

Sharing Your Medical Information

If you give permission for us to communicate with anyone/anybody else regarding your (or your minor child's) medical information please complete the list below. I understand that this permission only applies to verbal communication. I further understand that disclosure of copies of my medical record, or other written forms of my protected health information, will require my written authorization for each episode of release. This permission will become a permanent part of my medical record.

Name/Phone Number	Relationship	Options for Information
1.		☐ Billing ☐ Appointment ☐ Medical/Health
2.		☐ Billing ☐ Appointment ☐ Medical/Health
3.		☐ Billing ☐ Appointment ☐ Medical/Health

When sharing your medical information please initial if it is okay to share regarding:

____ HIV/AIDS, ____ Substance Abuse, ____ Mental Health _____ Genetic Testing

My signature below represents I have read and understand the terms and statements above. This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

Patient/Legal Representative Signature: _______________________________ Date: ________________

Relationship to patient (if not self): ____