Berks Community Health Center

Permitted Contacts for Disclosure of Your Protected Health Information

Patient's Name: _____ **Date of Birth:** _____

1. **APPOINTMENT REMINDERS:** We will send you <u>all</u> appointment reminders by text message and/or phone voicemail. If you do **NOT** want to get **text message appointment reminders,** check **HERE ❑.**

2. **PATIENT CONTACT NUMBERS:** We need to know where we may call you and if we may leave **<u>detailed</u>** messages about your healthcare on your home, work or cell phone voicemail. If we do not have your permission to leave detailed messages, our staff will only leave a brief message that you need to call BCHC.

Please list the patient's phone numbers. List phone numbers in order of preference:

Patient Phone Numbers	Home	Work	Cell	May we leave a detailed message on your voicemail?
1.	❑	❑	❑	❑ Yes ❑ No
2.	❑	❑	❑	❑ Yes ❑ No
3.	❑	❑	❑	❑ Yes ❑ No
4.	❑	❑	❑	❑ Yes ❑ No

3. **OTHER PEOPLE:** The privacy of your health information is our priority. We only share your "Protected Health Information" for purposes of treatment, payment or health center operations as permitted or required by law. Otherwise, we will only disclose and discuss your Protected Health Information with people you name as your authorized contacts on this form. **If you would like someone to be able to pick up your prescriptions for you, or drop off and pick up forms or other printed materials for you, they must be listed on this form.**

We will not share your mental or behavioral health information with anyone unless we have your permission to share that information below.

Please list the people you will allow to talk with your Provider and staff at BCHC about your healthcare, and who can pick up your prescriptions or paperwork for you.

Permitted Contact Name	Relationship	Phone #	May share physical health information	May share MENTAL HEALTH information	May pick up prescrip-tions	May pick up forms and paperwork
			❑Yes	❑Yes	❑Yes	❑Yes
			❑Yes	❑Yes	❑Yes	❑Yes
			❑Yes	❑Yes	❑Yes	❑Yes

❑ **I understand that I may change or revoke these permissions at any time by completing a new form.**

Would you like to receive health newsletters, and general information from BCHC via email? ❑ Yes ❑ No
If yes, what is your email address? _____

_____ _____
Signature of Patient/Parent or Personal Representative Date Signed

_____ _____
Print Name of Patient/Parent or Personal Representative Relationship to Patient