Form # PCC-1228-FFE
Orig 04/03 Rev 11/12

ACMH HOSPITAL
One Nolte Drive
Kittanning, PA 16201

# Patient Instructions Regarding PHI for ACMH Clinics

## Communication Preferences

Patient ID

To ensure proper and timely handling of your test results which have been ordered by your health provider, please complete the following:

| | |
|---|---|
| Home Address: | _____<br>_____<br>_____ |
| Home Phone#: _____ | Cell Phone #: _____ |
| Work Phone #: _____ | Alternate #: _____ |

I authorize my physician, physician group or staff member employed by the practice to release any and all medical test results or other medical information relating to my treatment to: **(initial all choices that apply)**

| Patient Initials | MEANS OF COMMUNICATION |
|---|---|
| | May leave a message at work to call the physician office. |
| | May leave a message on any (home or work) answering machine/voice mail to call the physician/service office. |
| | May leave a message on the home answering machine regarding the test result/treatment. |
| | May leave a message with a family member for me to call the physician office. |
| | May give test results/instructions to: _____<br>Name of Individual: _____ _____ _____<br>Relationship to you: _____ _____ _____ |
| | May only release test results to the patient. |
| | Other patient specific communication instruction:<br>May send text message confirming scheduled appointment. |

I understand this information used and these instructions will be in effect unless changed or revoked by me either in writing or by completing a new instruction form.

_____ Date

_____ Patient (legal representative) Signature