Patient Communication Form For Privacy Practices

Buchanan County Health Center
Here For You. Trusted For Life.

Our office will make an effort to notify you of your test/lab/procedure/etc. results, if necessary. You may instruct Cedar Valley Medical Specialists, P.C. as to the method of communication and who may and/or may not receive these communications.

Please Mark the Best Method of Communication

- ☐ Home Phone ( ) _____
- ☐ Cell Phone ( ) _____
- ☐ Work Phone ( ) _____
- ☐ Mailing Address _____
  _____
  _____
- ☐ Email Address _____

I give my permission for the following **TO RECEIVE** my Personal Health Information if necessary. (Optional)

Spouse (full name) _____ (Phone) _____

Child (full name) _____ (Phone) _____

Friend (full name) _____ (Phone) _____

Parent (full name) _____ (Phone) _____

Other (full name) _____ (Phone) _____

DO NOT give my personal Health Information to the following named person/persons.

(full name) _____ (Phone) _____

(full name) _____ (Phone) _____

I hereby acknowledge that I have been informed, that I may receive a copy of Cedar Valley Medical Specialists, P.C.'s Notice of Privacy Practices upon request.

☐ **Copy Provided** ☐ **I do not want a copy**

_____ _____
Patient's Signature and/or Guardian **Date**

_____ _____
Printed Name **Date of Birth**

_____
Guardian's relationship to patient