COMMUNICATION PERMISSIONS
FOR PROTECTED HEALTH INFORMATION (PHI)

Patients who are minors (under age 18) may request certain levels of confidentiality and consent to various health care matters depending on their age. Further details regarding this can be provided by NHC staff.

Patient Name:	**Date of Birth:**

IT IS OK FOR NEIGHBORHOOD HEALTH CENTER TO CONTACT YOU? *(please check all that apply)*:

1. Can we send bills to your address? ❑ Yes ❑ No
2. Can we send automated appointment reminders? ❑ Yes ❑ No
   If yes, which type? ❑ Phone call ❑ Text message
3. Can we send you newsletters via email? ❑ Yes ❑ No
4. Can we call you regarding your visit/treatment with us? Types of calls that could be made:
   - Primary Care (lab Results, medical instructions, referrals, medications, etc.) ❑ Yes ❑ No
   - Dental Care ❑ Yes ❑ No
   - Behavioral Health (follow up on concerns, referrals, etc.) ❑ Yes ❑ No
   - Reproductive Health (sexual health, STI treatment, test results) ❑ Yes ❑ No

Preferred Communication: ❑ Do not contact ❑ Mail ❑ Phone ❑Email via MyChart ❑ No preference ❑ Text

WHO MAY WE SPEAK TO REGARDING YOUR HEALTHCARE? *(NOTE: this is not an authorization to release records):*

I authorize Neighborhood Health Center to speak to the following people, in person or by telephone: ❑ Not Applicable

Name: **Relationship:**

Home #: **Work #:** **Mobile #:**

Preferred Language: **Interpreter Needed:** ❑ Yes ❑No

❑ Use this person as an emergency contact ❑ Authorized to sign on behalf of guardian in guardian's absence

Regarding *(please check all that apply)*: ❑ Schedule / cancel appointment ❑ Medical instruction / advice
❑ Prescription drug information ❑ Lab results ❑ Imaging results
❑ **All** information ❑ Other:

Name: **Relationship:**

Home #: **Work #:** **Mobile #:**

Preferred Language: **Interpreter Needed:** ❑ Yes ❑No

❑ Use this person as an emergency contact ❑ Authorized to sign on behalf of guardian in guardian's absence

Regarding *(please check all that apply)*: ❑ Schedule / cancel appointment ❑ Medical instruction / advice
❑ Prescription drug information ❑ Lab results ❑ Imaging results
❑ **All** information ❑ Other:

PLEASE LIST LEGAL REPRESENTATIVE, GUARDIAN, POWER OF ATTORNEY, ETC. IF ANY *(please provide proof)*

Name: _____ ❑ Not Applicable

Relationship: _____ **Phone:** _____

SIGNATURE REQUIRED *(below):*

The authorization may be changed or revoked in writing at any time. It will remain in effect until one (1) year from the date below. By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

Signature (Patient/Legal Guardian)	***Date***
Print Name	***Relationship (if not patient)***