Allegheny Health Network

Patient Confidentiality Form*

Patient Name: _____ Patient Date of Birth: _____

(Please Print)

Please check the appropriate box(es).

☐ List the family members or other persons, if any, whom we may inform about your health care and payment related to your health care:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

☐ List the family members or other persons, if any, whom are authorized to pick up health care information such as medical records, prescriptions, supplies, test results, etc. on your behalf:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

☐ Print the phone number(s) where you would like to receive calls about your appointments, lab and X-Ray results, or other health care information:

_____ May we leave detailed messages at this number ☐ YES ☐ NO

_____ May we leave detailed messages at this number ☐ YES ☐ NO

☐ You can communicate with me via e-mail at: _____

(Separate Authorization Form for e-mail communications must be signed)

_____ _____

Signature of Patient (or Representative) Date

- If Representative, specify relationship to patient and authority to act:

_____

_____

* This form is not intended to replace an Authorization, but it allows patients to choose an alternative method for communication about their health care.