If label not available, please fill in below:
NAME:)_____
DOB:_____
MRN:_____

PATIENT COMMUNICATION/PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION (PHI)

Patient Name	Date of Birth	Effective Date
Primary Phone	Other Phone	_____/_____/_____

My preferred method of communication (check only one):

☐ Primary phone ☐ MyKeystone Portal ☐ Other phone ☐ Other:_____
(If Keystone is unable to reach you via the preferred method, we will use other available methods.)

The following information may be left on the phone:

☐ Detailed Message (including any information related to treatment or payment)

☐ Message requesting a return call

☐ **NONE**

PARENTS/LEGAL GUARDIANS, PLEASE INCLUDE YOUR NAME ON THE FORM

Name of legal guardian(s)_____
Relationship:_____
Name of legal guardian(s)_____
Relationship:_____

I give permission for Keystone to VERBALLY share any non-confidential information with family, friends, or others that I have identified below as being involved in my health care, care coordination, or payment of my health care.

Name:_____ **Relationship**_____ **Phone**_____

Check all that apply:

☐ Appointment information
☐ Medical/Dental information, including my symptoms, diagnosis, medications, and treatment plan
☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan
☐ Lab/test results ☐ HIV results ☐ Billing and payment information ☐ Pick up forms(orders, results)
☐ Other (describe): _____

Name:_____ **Relationship**_____**Phone**_____

Check all that apply:

☐ Appointment information
☐ Medical/Dental information, including my symptoms, diagnosis, medications, and treatment plan
☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan
☐ Lab/test results ☐ HIV results ☐ Billing and payment information ☐ Pick up forms(orders, results)
☐ Other (describe): _____

Name:_____ **Relationship**_____ **Phone**_____

Check all that apply:

☐ Appointment information

☐ Medical/Dental information, including my symptoms, diagnosis, medications, and treatment plan

☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan

☐ Lab/test results ☐ HIV results ☐ Billing and payment information ☐ Pick up forms(orders, results)

☐ Other (describe): _____

Name:_____**Relationship**_____**Phone**_____

Check all that apply:

☐ Appointment information

☐ Medica/Dental information, including my symptoms, diagnosis, medications, and treatment plan

☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan

☐ Lab/test results ☐ HIV results ☐ Billing and payment information ☐ Pick up forms(orders, results)

☐ Other (describe): _____

Schools

The following is to be completed for patients that are of school age (under 18):

As parent/legal guardian of this minor child, I agree to have Keystone Health provider(s) disclose proof of immunizations to the school noted below.

School Name: _____

School District: _____

Other:_____

I understand that in certain situations Keystone may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that certain confidential information may not be shared without my explicit consent.

I understand that I have the right to revoke my permission at any time except where Keystone has already made disclosures based upon this request. I understand this permission remains in effect until I complete and submit a revised form.

This form does not authorize releasing copies of my records except for immunization records to schools.

Indicate relationship to patient: ☐ Patient ☐ Patient Representative Relationship_____

_____ _____

Signature of Patient/Representative Date

**********Office Use Only**********

Received by:_____ Date:_____ Site:_____

Completed by:_____ Date:_____