Today's Date:______________________________

Patient Number:

PATIENT COMMUNICATION FORM

Authorization for Verbal Communication and/or to Leave Voice Mail Messages Regarding My Personal Health Information and Permission to Invite Me to Participate in Follow My Health Patient Portal. ***This does not authorize release of copies of medical records without a signed Authorization to Release Medical Records by patient or guardian***

Name- Last, First, MI ____Date of Birth:______________________

Information to be disclosed: verbal communication only regarding patient's care-no copies of medical records provided
Please Provide your current telephone numbers:
Home Phone Cell Phone_____________________________
Work Phone Other Phone____________________________

We normally contact our patients between 8 a.m. and 5 p.m. Monday through Friday. Please check below where you would prefer to be contacted during these hours.

Home Phone__________ Cell Phone___________ Work Phone___________ Other Phone___________

If we need to reach you after hours, please check below where you prefer to be called:

Home Phone__________ Cell Phone___________ Work Phone___________ Other Phone___________

Your Protected Health Information Designees:
If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information).
This person (designee) will also be able to call the office on your behalf.
Please print the name and relationship to you/patient of each designee below:

Designee Name: Relationship to Patient:____
Designee Name: Relationship to Patient:____
Designee Name: Relationship to Patient:____

______ Check here if you **DO NOT** want your health care information discussed with anyone other than yourself.

Confidential Voice Mail:
Please check below where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) blank if you **DO NOT WISH** to receive voice mails.
Home Phone__________ Cell Phone___________ Work Phone___________ Other Phone___________

Information for Follow My Health Patient Portal:
Please **write below** an email address that we can send you a invite to participate in our new patient portal. The portal allows you the ability to communicate with River Valley Healthcare Associates in regards to: appointment requests, medication refill requests, and allows bidirectional communication between you and your provider and allows them to personally inform you regarding labs and other test results.
Email Address:____

Your signature **below** confirms your approval of these updated HIPPA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

_______________________________________ ____________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Today's Date:___________________________________

Patient Number:

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

River Valley Healthcare Associates honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Sending Authorizations to **River Valley Healthcare Associates**: If mailing an authorization, please mail to either address: **River Valley Healthcare Associates**, 28 Town Center Drive, Dublin, VA 24084

Verbal Communication Only. This authorization allows for verbal communication (both in person and on the telephone between **River Valley Healthcare Associates** and the designated person(s) on this form. It does not allow for copies of medical records to be released.

Voice Mail Messages. **River Valley Healthcare Associates** Providers and their staff recognize confidentiality as a very important part of your relationship with them. To protect your confidentiality, they will not routinely leave messages on your personal messaging system (voice mail or answering machine or with your spouse, family members or any other individual) unless you specifically give your permission to do so. This authorization may be used to share this information in the manner that you specify.

Follow My Health Patient Portal. Your email that you provide is for the specific use of **River Valley Healthcare Associates** providers and staff for the sole purpose of communicating with you regarding your health. This information will not be shared. Follow My Health is a secured website that uses SSL when logging in to maintain security. If you would like additional information regarding the security features of Patient Portal, please ask a a staff member for a facts sheet or go to www.rvha.life then click on the ***Patient Portal*** tab at the top of the page.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so for either all or part of it. Except as permitted under applicable law, **River Valley Healthcare Associates**, Providers may not refuse to provide you treatment or other healthcare services if you refuse to sign.

Revocation. You have the right to revoke this authorization, in writing at any time. However, your written revocation will not affect any disclosures of your medical information that the person(s) listed on the release form have already made, in reliance on this authorization, before the time that you revoke it.