Allegheny Health Network

Saint Vincent

Saint Vincent Medical Group

Personal Communication of Your Patient Information

NAME _____ **Date of Birth** _____

There may be times when we need to contact you with information, or when you may want us to tell others, such as family or friends, about your condition or treatment. I hereby grant permission to the Designated Persons named below to: make or confirm my appointments; have access to my X-ray, laboratory, and test findings; pick up medications for me; be made aware of my diagnosis, prognosis and treatment plans in person or by telephone as indicated below; and have access to financial information relating to my health care. We refer to this type of communication as "Personal Communication"

Many Saint Vincent Medical Group (SVMG) locations utilize an "integrated" Electronic Health Record which enables our providers and staff involved in the care of our patients to access and update their electronic health information for any SVMG location utilizing our "integrated" Electronic Health Record. Please see the last page of this document for a list of those SVMG locations utilizing our "integrated" Electronic Health Record.

Please fill out this form to help guide us in providing Personal Communications about you.

Communications with Designated Persons:

Please indicate who else (if anybody) we may use and disclose your health information for the above purposes in order to enable the Designated Person(s) to assist you with your care.

____ No one
____ My Spouse, please name: _____ phone: _____
____ My Children please name: _____ phone: _____
____ My Parent(s) please name: _____ phone:_____
____ Others:_____ phone:_____

Communications with Schools: _____ YES _____ NO

With your authorization we will provide certain documents containing health information to the school nurse and/or other school representative/office upon their or your request. We will provide this information via telephone, general mail or by fax if you provide us the fax number. If you authorize these disclosures, please provide the following information;

Name of school authorized to request/receive documents indicated below:_____
Name of School Nurse and/or other school representative/office authorized to request/receive documents as indicated below:
School Nurse: _____ Phone: _____
Other School Representative/Office: _____ Phone: _____
School Fax Number if information is to provided via fax: _____
Indicate those Documents we are authorized to provide to the school representative(s) listed above:

____ Last Well Visit Records
____ Physical Forms
____ School/Work Excuse
____ Immunization Records
____ Medication List
____ Allergy/Asthma Action Plans

(With verbal release, we can release immunization records only)

Communications with You: If you are enrolled in MySV Patient Portal, you have access to your SVMG Personal Health Information via your secure MySV account. We will use MySV Patient Portal as our preferred/first method of communicating.

If we need to contact you by telephone we will use the number you have given us. If you want us to contact you a number different than what we have on file, please list it here:

_____.

If we need to use regular mail to provide Personal Communication to you we will use the address you have given us. If you want us to use an address different than what we have on file, please list it here:

_____

_____

Requests for Restrictions: If there are any other specific requests for restriction on Personal Communication that you would like to make, please note them here:

_____

_____

I understand the following with respect to this form:

- This authorization will automatically expire at the end of each calendar year unless you indicate an alternate expiration date (Alternate Expiration Date): _____.
- I may refuse to complete/sign this form. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- If completed at a SVMG location utilizing our "integrated" Electronic Health Record, this form will be effective for **all** the Saint Vincent Medical Group locations utilizing our "integrated" Electronic Health Record for the term indicated in first bullet point above unless otherwise specified.
- If the person(s) receiving information about me through Personal Communication is not a health care provider or a health plan covered by Federal Privacy Regulations, the information may be re-disclosed and no longer protected by Federal Privacy Regulations.
- I may change or revoke this form in writing at anytime, for future Personal Communications.
- If SVMG is able to agree to this request, it will supersede any previous made for this patient. SVMG will notify you if unable to agree to any section of this request.

_____ _____

Signature of patient or patient's legal representative | Patient Date of Birth

_____ _____

Print patient's name | Date

_____ _____

Print name of legal representative (if applicable) | Relationship to patient

NOTE: List of SVMG Locations utilizing the Integrated Electronic Health Record will be provided upon your request.

MR1001

SAINT VINCENT HEALTH SYSTEM
ERIE, PENNSYLVANIA

Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have received a copy of Saint Vincent Health Systems' Notice of Privacy Practices.

Patient Signature: _____

Date: _____

Or

Signature of Personal Representative: _____

Date: _____

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

_____

Declaración de Recibo del Aviso Sobre la Privacidad

Declaro que he recibido una copia del Aviso sobre las Prácticas de la Privacidad de *Saint Vincent Health Systems.*

Firma del Paciente: _____

Fecha: _____

Ó

Firma del Representante Personal: _____

Fecha: _____

Si arriba aparece la firma del Representante Personal, por favor describa el parentesco de dicho Representante con el paciente:

_____

_____