Advanced Primary & Behavioral Health

Patient Name: _____ Date of Birth: ___ / ____ / _____

To protect your privacy, we ask that you complete this form so we know the ways in which we may communicate with you regarding your health information. Please mark as many of the communication options below you feel comfortable with so we have multiple ways to reach you regarding important matters concerning your health care.

I prefer to receive my appointment reminders in the following method: ____ Text message ____ Phone call

I authorize Advanced Primary & Behavioral Health, LLC, its provider's, and employees, to do the following:

Yes	**No**	**Leave a message at my home/cell number regarding appointment reminder/scheduling It is important that you always keep your home/cell number updated with the office**
Yes	**No**	**Send me a letter in the mail regarding appointment reminders, test results and/or scheduling needs.**
Yes	**No**	**Leave my test results in a message at my home/cell number.**
Yes	**No**	**Send my appointment reminders in a text message.**

I authorize Advanced Primary & Behavioral Health, LLC to discuss my healthcare with the following individuals:

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

I understand that I have the right to change or cancel this request at any time by notifying the office, in writing, at 789 Eastern By-Pass Ste 10, Richmond, Ky 40475

_____ _____

Signature of Patient/Representative Date Printed Name of Patient/Representative

_____

Signature of Witness Date