

Armstrong Orthopedic Associates, L.L.C.

316 First Avenue • Suite 275
Kittanning, PA 16201

Patient Name _____

Social Security # _____

Patient Instructions Regarding PHI for Armstrong Orthopedic Associates

Communication Preferences

To ensure proper and timely handling of your test results which have been ordered by your health provider, please complete the following:

Home Address:	
Home Phone:	
Work Phone #:	
Cell Phone #:	
Alternate #:	

I authorize my physician, physician group or staff member employed by the practice to release any and all medical test results or other medical information relating to my treatment to: **(initial all that apply)**

Patient Initials	MEANS OF COMMUNICATION
	May leave a message at work to call the physician office.
	May leave message on any (home or work) answering machine/voice mail to call the physician/service office.
	May leave a message on the home answering machine regarding the test result / treatment.
	May leave a message with a family member for me to call the physician office.
	May give test results/instructions to: Designee's Name: _____ Relationship: _____
	May only release test results to the patient.
	Other patient specific communication instruction (for example, person you would object to sharing information with):

I understand this information used and these instructions will be in effect unless changed or revoked by me either in writing or by completing a new instruction form.

_____ Date

_____ Patient (legal representative) Signature