KENNEDY HEALTH ALLIANCE™

Confidentiality Code

In order to protect your privacy, please provide Kennedy Health Alliance with a confidentiality code that allows you to select only those individuals that you wish to have access to you or your child's protected health information [PHI]. You will be asked to provide this code before we can discuss any of your Protected Health Information over the phone. This code does not apply to other disclosures of your PHI permitted by the Privacy Rule. Protecting the privacy of your patient information is a priority for Kennedy Health Alliance [KHA].

We would strongly suggest that you select four [4] numbers or a code word for your confidentiality code that someone outside of the approved parties could not easily figure out (e.g. date of birth).

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____ _____ _____ _____

Four (4) Digit Code **Code Word**

*****_By signing in the box below, I have chosen to OPT OUT meaning that I am NOT giving anyone, except for myself, access to my health information. I understand that by signing this form only I can receive information regarding my PHI. I am also aware that I can change this decision at any time by completing a new form._

Signature:	***Date Signed:***

In order to obtain any patient information from a KHA practice, you will need to provide your name and confidentiality code. You should know that **without** the code we will not be able to provide you with any confidential information. The Confidentiality Code will expire one year from the date signed and must be completed on an annual basis.

Requests for in-depth or sensitive clinical information, such as HIV and STD, testing results, etc. cannot be disclosed via the phone and will be re-directed to your treating provider who may feel that a face-to-face visit is needed.

PERMISSION TO LEAVE MESSAGES

Should my KHA provider or staff need to reach me to discuss a matter involving my health information, by checking "agree" below KHA has my permission to leave appointment reminders and non-specific call back messages on my personal voicemail, answering machine or to a third party whom I have identified as a contact. I understand that I may change this designation at any time by completing a new form.

_____I **agree** to receive messages as described above

_____I **do not agree** to receive messages as described above.

Patient: _____DOB:_____

Guardian Name (if applicable): _____Relationship to Patient:_____

Signature of agreeing party: _____

For Office Use Only

Received by: _____ *Date:* _____ *Copy given to patient: Yes / No*

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