IU Health Physicians

Patient Sticker Here

PREFERRED COMMUNICATION LIST

In caring for our patients, it may be necessary to contact you by telephone. If you are not available when we call, we would like to be able to leave telephone messages when possible. There are also times where you may want us to communicate labs, medication, treatment plans, or billing information to a trusted friend or family member. In order to protect your privacy, we need your written permission to leave messages on the phone or with another person you designate concerning you or your child's treatment and health care.

WAYS OUR OFFICE CAN COMMUNICATE WITH YOU ABOUT YOU OR YOUR CHILD

If we are unable to reach you directly to communicate medical information concerning you or your child, how would you like to receive health information? **Please check all that apply:**

☐ **I DO PERMIT** IU Health Physicians to leave voice mail at the following numbers. Check all that apply and provide information below:

Preferred phone #1: _____ Name: _____ _____ (Relation to Patient)

Preferred phone #2: _____ Name: _____ _____ (Relation to Patient)

☐ **I DO NOT PERMIT** IU Health Physicians to leave voice mail on my phones.

FAMILY AND FRIENDS COMMUNICATION

Please complete the back page of this form with names of individuals the practice is able to communicate with. I give approval for IU Health Physicians staff to speak with designated family or friends concerning my, or my child's, treatment and health care. ☐ Yes ☐ No

IU Health Physicians will not release any information on voice mail or to family or friends regarding HIV, sexually transmitted diseases, pregnancy tests or contraceptive counseling. This information will be released only to the patient, and to any public health agency to which IU Health Physicians is legally bound to report such information, unless otherwise permitted by law.

IU Health Physicians is committed to ensuring the privacy and security of patient health information. Reasonable steps will be taken to give you, as our patient, an opportunity to agree or object to the release of specific medical information. I understand this permission is valid until revoked by me. I understand that if I choose to revoke this authorization, I must do so in writing and provide to the office staff at this practice.

Patient Name _____ **Date of Birth** _____

Patient/Guardian Signature _____ **Patient/Guardian Printed Name** _____ **Date** _____

Other Consent

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Patient Sticker Here

<u>FAMILY & FRIENDS COMMUNICATION:</u>
I permit IU Health Physicians to communicate with family and friends identified below who are involved with my health care or payment the following relevant information about me or my child. I understand that this information may be subject to re-disclosure by my family and friends, and that the disclosed information is then beyond the privacy protections of the practice. IU Health Physicians will not release any information regarding HIV, sexually transmitted diseases, pregnancy tests, or contraceptive counseling.

Authorized Individual	Phone Number	Relationship to Patient

The above named person may receive the following information about my treatment and healthcare (please check all that apply):

- ☐ Any and all information
- ☐ Information necessary to schedule, confirm, cancel or reschedule appointments
- ☐ Information about test results
- ☐ Information about prescriptions / prescription pick-up
- ☐ Information about my bills or account

Authorized Individual	Phone Number	Relationship to Patient

The above named person may receive the following information about my treatment and healthcare (please check all that apply):

- ☐ Any and all information
- ☐ Information necessary to schedule, confirm, cancel or reschedule appointments
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Patient Name **Date of Birth**

Patient/Guardian Signature **Patient/Guardian Printed Name** **Date**