Patient Sticker Here

# COMMUNICATION CONSENT FORM

*The purpose of this form is to obtain guidance from you (the patient) about how we should communicate about you and to you.*

**Date of Request:_____ Patient Name:_____DOB:_____**

**SECTION 1: Communications to Family Members and Others Involved in My Healthcare**

I give my permission to Primary Health Care, Inc. to communicate information concerning my healthcare and financial/insurance information (which may include history, diagnosis, labs, test results, treatment and other health information) to the person(s) listed below. ***Note: If the patient is a minor, pursuant to Iowa law, information generally will be given to both parents unless Primary Health Care, Inc. otherwise deems the communication inappropriate).***

| | | |
|---|---|---|
| **Name 1:_____** | _____ Relationship | _____ Phone No. |
| **Name 2:_____** | _____ Relationship | _____ Phone No. |
| **Name 3:_____** | _____ Relationship | _____ Phone No. |

I understand that it is my responsibility to update the above information if I want it changed. This communication information will be used for all medical/dental conditions and treatment obtained at Primary Health Care, Inc. or at the request of one of the providers employed at Primary Health Care, Inc.

I understand that mental health, substance abuse treatment and/or HIV information may **not** be disclosed pursuant to this form and that a HIPAA-compliant Authorization for Release of Protected Health Information form must be completed to disclose any mental health, substance abuse treatment and/or HIV information. Additionally, I understand that if there are exceptions to the communications permitted pursuant to this form, it is my responsibility to notify Primary Health Care, Inc.

**Note: This form does not provide the above-named person(s) with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner or representative, or if you wish to set up a living will, please discuss this with your provider or your attorney.**

**SECTION 2: Standard Methods to Communicate to Me (the patient)**

I agree to allow Primary Health Care, Inc. to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize Primary Health Care, Inc. to leave messages for me when I am unavailable. (***Note: Detailed messages will not be left on an answering machine or voicemail that does not clearly identify the recipient.)***:

| | | | |
|---|---|---|---|
| My Home Answering Machine | □ Yes | □ No | Home #: _____ |
| My Work Answering Machine | □ Yes | □ No | Work #: _____ |
| My Cell Phone Voicemail | □ Yes | □ No | Cell Phone #: _____ |
| Email | □ Yes | □ No | Email Address: _____ |
| Text Messages | □ Yes | □ No | Cell Phone #: _____ |

(*Standard text message rates may apply; only appointment reminders and general health education will be sent by text message.*

**This form will be in effect until for 1 year from the date on which it was signed. I understand that I may revoke this authorization at any time.**

_____ _____

**Signature of Patient or Legal Guardian** **Date**

_____

**Relationship (if not patient)**