Southern Indiana Physicians

PREFERRED COMMUNICATION LIST

Patient Sticker

IU Health Southern Indiana 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.

PATIENT COMMUNICATION:

☐ I permit IU Health Southern Indiana Physicians to communicate the identified information below by leaving voice mail at the following numbers.

Preferred phone #1:_____ Secondary phone #2:_____

- ☐ Information about normal test results
- ☐ Information about prescriptions / prescription pick up

☐ I do **NOT** permit IU Health Southern Indiana Physicians to leave voice mail on my phones.

FAMILY & FRIENDS COMMUNICATION:

I permit IU Health Southern Indiana Physicians to communicate with family and friends, as identified below, the following information about my treatment and health care.

1. **Authorized Individual** _____ **Phone Number** _____ **Relationship** _____
   - ☐ 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
2. **Authorized Individual** _____ **Phone Number** _____ **Relationship** _____
   - ☐ 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
3. **Authorized Individual** _____ **Phone Number** _____ **Relationship** _____
   - ☐ 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

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.

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. I understand IU Health Southern Indiana 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 Southern Indiana Physicians is legally bound to report such information.

(Optional) I would like my code word to be _____.

Patient Name _____ **Date of Birth** _____

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

Witness Signature _____ **Witness Printed Name** _____ **Date** _____