Indiana University Health

Consent for Preferred Communications English

Patient Label

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. **This form is used through all of IU Health facilities and physician practices and is valid until revoked by you in writing or until it is replaced with a new form.**

Please complete the following questions:

Cell Phone Number: _____

We can call you on your cell phone	O Yes	O No
We can leave a message on your cell phone voicemail	O Yes	O No

Home Phone Number: _____

We can call you on your home phone	O Yes	O No
We can leave a message on your home phone voicemail	O Yes	O No

Work Phone Number: _____

We can call you on your work phone	O Yes	O No
We can leave a message on your work phone voicemail	O Yes	O No

FAMILY AND FRIENDS COMMUNICATION

I give approval for IU Health staff to speak with designated family or friends concerning my or my child's treatment and health care. 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 protection of IU Health. IU Health will not release any information to family or friends regarding HIV, sexually transmitted diseases, psychotherapy notes, drug and alcohol treatment, pregnancy tests or contraceptive counseling unless specifically authorized in a separate authorization. **If yes**, please provide the names of individuals IU Health is able to communicate on your behalf. **If more than one individual, please see the second page.**

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

Patient/Guardian Signature | Patient/Guardian Printed Name | Patient's Date of Birth | Date

Patient Label

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

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- ☐ 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

If side 2 is completed, please have the patient/guardian initial below.

Patient/Guardian initials: _____