

## Patient Preference Regarding Communication of Health Information

In order to better protect your privacy under HIPAA, we have created this consent form for releasing medical information to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the phone numbers listed below, mail your lab results to your home and also send secure email results to your personal email address once enrolled in MyChart. We are legally not allowed to release medical information to patient family members without the patient's written consent. The purpose of this document is to protect your privacy.

Is it permissible to:	Yes	No	Please provide:
Call your home?			<b>Home Phone #:</b>
Leave a message at home ?			Primary: [ ]    Secondary: [ ]    Third: [ ]
Call your work ?			<b>Work Phone #:</b>
Leave a message at work ?			Primary: [ ]    Secondary: [ ]    Third: [ ]
Call your cell phone ?			<b>Cell Phone #:</b>
Leave message on cell phone?			Primary: [ ]    Secondary: [ ]    Third: [ ]
Mail results to your home?			<b>Address:</b>
E-Mail results to your home?			<b>E-Mail Address:</b>

**Communication to Family Members, Spouses or Other:**

I, (print patient name) \_\_\_\_\_ DOB \_\_\_\_\_, hereby give my permission for the release of medical information regarding appointments and questions about my condition and treatments to the following person(s):

**Contact #1:** \_\_\_\_\_  
**Relationship:** \_\_\_\_\_  
**Home #:** \_\_\_\_\_  
**Work#:** \_\_\_\_\_  
**Cell:** \_\_\_\_\_  
**Emergency Contact: (Y/N)** \_\_\_\_\_

**Contact #2:** \_\_\_\_\_  
**Relationship:** \_\_\_\_\_  
**Home #:** \_\_\_\_\_  
**Work#:** \_\_\_\_\_  
**Cell:** \_\_\_\_\_  
**Emergency Contact: (Y/N)** \_\_\_\_\_

**Communication for Appointment Reminders and Appointment Follow-Ups:**

Methodist Transplant Specialists ("MTS") may need to use your name, phone number, email address ("Contact Information"), and your clinical records to contact you with appointment reminders and information about treatment alternatives, If this communication is made by phone and you are not available, a message will be left on your voice mail or with the person answering the phone. By signing this form, you are consenting for MTS to contact you with appointment reminders and information and to leave messages on a voice mail or with individuals at you home. Information that we use or disclosed based on this consent may be subject to re-disclosure by anyone who has access to the reminder and my no longer be protected by federal privacy rules.

You have the right to refuse to give MTS your consent to use your telephone number and/or email address for appointment reminders and treatment alternatives. If you chose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give MTS this consent or revoke it in the future, it will not affect the treatment we provide to you.

I CONSENT to the following forms of communication for appointment reminders and follow-up communication (Initial all that apply): \_\_\_\_\_ Email (If Applicable) \_\_\_\_\_ Phone \_\_\_\_\_ Text message (If Applicable) <sup>1</sup> \_\_\_\_\_ Secure patient portal to be used in the manner described above.  
 Preferred Email Address \_\_\_\_\_ Preferred Telephone Number \_\_\_\_\_