Consent to Communication

UnityPoint Health

The purpose of this form is to obtain guidance from you (the patient) about how UnityPoint Health, its affiliates listed within our Notice of Privacy and Practices, and its Business Associates (collectively "UPH") communicate about you and to you in the ways you prefer.

Patient Information

Date of Request:_____/_____/ _____

Patient Name: _____ Date of Birth:_____/_____/_____

Patient Address: _____

City State Zip

SECTION 1: Standard Methods to Communicate to Me (the patient)

Detailed information regarding my medical condition and medical treatment may be left on or sent via:

My Cell Phone Voicemail	☐ Yes	☐ No	Cell number is:
Text Messages (including Standard SMS) (Standard message and data rates may apply)	☐ Yes	☐ No	
My Home Voicemail	☐ Yes	☐ No	Home number is:
My Work Voicemail	☐ Yes	☐ No	Work number is:
My Email	☐ Yes	☐ No	Email address is:
Other electronic communications (e.g., web- or mobile-based applications, internet-connected digital devices)	☐ Yes	☐ No	n/a

TELEPHONE, E-MAIL, AND OTHER ELECTRONIC COMMUNICATIONS: I consent to UPH and its affiliates using any telephone numbers (including cell phone/wireless numbers), email addresses, and other electronic communications I provide to UPH for appointment, referral, treatment, billing, debt collection, and other purposes related to my care. This includes automated calls, pre-recorded/artificial voice messages, and all other calls, text messages, emails, and other electronic communications. If I discontinue use of any phone number provided, I shall promptly notify UPH and will hold UPH and its affiliates harmless from any expenses or other loss arising from any failure to notify. I understand that standard text messages, unencrypted emails, and other electronic communications that I send and receive from UPH may flow through networks that are not secure and may be at risk of exposure of my health information (for example, the message could be intercepted and viewed by an unauthorized third party). In addition, once the text, email, or other electronic communication is received by me, someone may be able to access my phone, applications, digital devices, or email accounts and read the message. I understand that it is my responsibility to make sure that only authorized people are allowed to access your email, phone messages, cell phone, and digital devices. I understand these risks and give permission to UPH to communicate with me via wireless/cell phone, unencrypted email, and other electronic communications.

PATIENT LABEL

SECTION 2: Communications to Family Members and Others Involved in My Healthcare

EXPLANATION: UPH and its affiliates may communicate with your family members and friends involved in your care or payment for your care. The purpose of this Section is for you to identify those individuals with whom you want UPH and its affiliates to communicate about you. In addition to those individuals you list below, UPH and its affiliates also may communicate with other individuals it determines in its professional judgment are involved in your care or payment and communicating with such individuals would be in your best interest. Note: By designating any individual below, it does not provide such individual with any authority over any treatment or care decisions. If you wish to designate a health care representative through a Durable Power of Attorney for Health Care, or if you wish to set up a living will, please discuss this with your primary healthcare clinician or your attorney.

I give my permission to UPH and its affiliates to communicate information regarding my care to the person(s) listed below. ***(Note: If the patient is a minor, information will be given to both parents unless deemed inappropriate pursuant to state law or court order.)***

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. If individuals other than you receive your health information sent in the ways allowed on this form, they may share it with others and state and federal privacy laws will not protect it.

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 Patient Authorization to Release Information form must be completed to disclose any mental health, substance abuse treatment and/or HIV information.

By signing below, I understand and consent to have UPH communicate with me and others as described above. This may include communications via standard SMS text messaging, email, and other electronic communications regarding various aspects of my medical condition and treatment, which may include, but shall not be limited to, test results, prescriptions, appointments, billing, payment, referrals, screening for a condition, monitoring of my condition, and general health care operations. I understand that standard SMS text messaging, email, and other electronic communications are not confidential or secure methods of communication. I further understand that, because of these methods, there is a risk that standard SMS text messaging, email, or other electronic communications regarding my medical condition and treatment including my personal health information might be intercepted, read by a third party, and/or used for inappropriate purposes.

This form will be in effect until revoked, but I may be asked to confirm the information with a new dated signature on an annual basis. Any revision or revocation shall be made in writing by completing a new form to include your signature and date of completion.

Signature of Patient or Legal Guardian_____ Date _____/_____/_____

Relationship (if not patient) _____

PATIENT LABEL