Patient Authorized Methods of Communication

This form will be used in talking with the patient or legally authorized person for the patient to request a different means of communication other than face to face between the patient and the provider. This form is for use only in a clinic situation and not while the patient is in the hospital.

This will apply to all Heart and Vascular Institute of Wisconsin Locations.

Patient information:

Name: ________________________________ Date of Birth: ____________________________
Address: ______________________________ City: ______________ State: ____ Zip: __________
Primary Care Physician: ____

Patient Authorized methods of communication:

Not all methods of communication offer the same level of privacy. For instance, other family members may have access to family account emails, answering machines, or other methods of communication. I understand the risks of disclosure of my personal information associated with each of the following means of communication.

You may check more than one:

□ Online/Email________________________
□ Voice mail/answering machine at telephone numbers: ________________/_______________
□ Fax number: ____________________________
□ Standard mail delivery
□ Alternative mail delivery location:
Address: ___________________________ City: __________ State: ______ Zip: _________

Effective timeline for authorization:

This authorization shall remain in effect until:

□ My death
□ I authorize a change or revoke in writing

Your rights with respect to this authorization:

Right to Inspect or Copy the Health Information to be Used or Disclosed- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. Right to Receive Copy of this Authorization-I understand that if I agree to sign this authorization, which I am not required to do so, I must be provided with a signed copy of the form. Right to refuse to sign this authorization I understand I am under no obligation to sign this form and the person(s) and/or organization (s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to Withdraw this authorization- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department. I am aware my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s)and or organization(s) listed above have already made in reference to this authorization.

Patient signature: ________________________________ Date: _______/________/________

Person authorized by patient or legal guardian: ____________________ Date: _______/________/________