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 (please print:

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: ____ Zip: _____
Name of Your 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:

☐ **Please sign me up for the Patient Portal via the following e-mail address:**
_____

☐ Voice mail/answering machine at telephone numbers: _____/_____

☐ Fax number: _____

☐ Standard mail delivery

☐ Alternative mail delivery location:
Address: _____ City: _____ State: _____ Zip: _____

My Medical Information can be released to others (Specify below for each individual):

I authorize the information described in this document to be released to the person(s) authorized below.

A. Information regarding appointment: diagnosis and procedures, cares planned, test results, statement of condition. Information for the purpose of assisting with billing: diagnosis, coverage, and payments. Information to support the planning of care services, i.e., transportation, appointments, home care, durable medical equipment.
B. Sensitive test results such as HIV, Pregnancy, sexually transmitted diseases.
C. Other: Patient is to specify: _____

Individuals Permitted To Be Informed About My Status (One or more please print):

Name: _____ Phone# _____ Relationship:_____

Choices (circle your choice(s)): A B C

Name: _____ Phone# _____ Relationship:_____

Choices (circle your choice(s)): A B C

----------NOTE: THIS FORM CONTINUES ON THE NEXT PAGE----------

Effective timeline for authorizations identified on this form:

These authorization(s) shall remain in effect until:
□ My death
□ I authorize a change or revoke my authorization 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- 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: _____/ _____/_____