St Luke's
PHYSICIAN GROUP

MEDICAL COMMUNICATION CONSENT

If you would like information disclosed to someone other than yourself, please complete the following information. List the name of the authorized person:

NAME	**RELATIONSHIP**
_____	_____ (primary contact)

To help out health care team focus on providing the best care for our patients, we ask that your designated primary contact stated above <u>be the ONLY person to request updates on your condition</u> while you are a patient at our facility.

I understand that this consent may be revoked by me at any time by submitting a written revocation notice.

In emergency situations, in accordance to the HIPAA Privacy Rules, clinical staff using their professional judgment may disclose protected health information as deemed necessary.

I authorize St. Luke's University Health Network to leave medical information pertaining to my care by the following methods and will assume the responsibility to notify St. Luke's University Health Network staff whenever the information changes.

Home Telephone:	□ **YES**	□ **NO**	_____
Answering Machine:	□ **YES**	□ **NO**	_____
Work Phone:	□ **YES**	□ **NO**	_____
Voice Mail:	□ **YES**	□ **NO**	_____
Cell Phone:	□ **YES**	□ **NO**	_____
Pager:	□ **YES**	□ **NO**	_____

_____ _____ _____
Patient's Signature Date Time

_____ _____ _____
Signature of Authorized Person Date Time

_____
Relationship

□ Unable to sign because: _____

Staff Signature:_____ Date: _____ Time: _____