UNIVERSITY MEDICAL CENTER
(Hereinafter referred to as UMC)

PATIENT COMMUNICATION CONSENT FORM

I agree to allow UMC to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize UMC to leave messages for me when I am unavailable.

PREFERRED CONTACT NUMBER

<table>
<thead>
<tr>
<th>NUMBER/ADDRESS</th>
<th>MESSAGES (YES OR NO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone</td>
<td></td>
</tr>
<tr>
<td>Cell Phone</td>
<td></td>
</tr>
<tr>
<td>Work Phone</td>
<td></td>
</tr>
<tr>
<td>Text Messages</td>
<td></td>
</tr>
<tr>
<td>Patient Portal</td>
<td></td>
</tr>
</tbody>
</table>

(Texting requires that you give us your cell number and for you to have a text enabled cell phone plan)

______ Home Phone (___) __________________________ Yes No
______ Cell Phone (___) __________________________ Yes No
______ Work Phone (___) __________________________ Yes No
______ Text Messages (___) ________________________ Yes No
______ Patient Portal Registration required (Ask nurse to register you for this free service).

Security Questions:
What is your mother’s maiden name? ______________________________
What is the name of your childhood best friend? _______________________
What is the brand of your first car? _________________________________

I authorize UMC and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below.

I understand that by leaving spaces blank I am indicating my choice to be a “No Information” and I do not want any information released to anyone else.

NAME RELATIONSHIP TO PATIENT CONTACT INFO
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

EMERGENCY CONTACT ONLY -
NAME: __________________ Phone: __________________

By my signature below I acknowledge that I have read and understand the Guidelines to Patient Communication and information provided on this consent form. I understand the risk associated with the different methods of communication and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that UMC may impose.

________________________________________________________
Patient name printed Date

________________________________________________________
Patient/Authorized Signature Relationship to Patient