Patient Name __________________________

Date of Birth __________________________

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

NUMBER/ADDRESS

MESSAGES (YES OR NO)

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

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

☐ Yes ☐ No

_________________________________@_______________._________

Email to be used for Patient Portal Registration Only
Do not email patient except through Patient Portal.

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 that I do not want any information released to anyone else.

NAME

RELATIONSHIP TO PATIENT

CONTACT INFO

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

I authorize the following person(s) to pick up prescriptions. (Please check the Controlled Substance Form)

____________________________________________________________________________________

____________________________________________________________________________________

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.

________________________________________  __________________________

Date

Patient name printed

Patient/Authorized Signature  Relationship to Patient