

\*Consent to Communication\*

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Request: | / / |  | |  | |  | |
| Patient Name: |  | | |  | Date of Birth: | / / | |
| Patient Address: |  | |  | |  | |  |
|  |  | | City | | State | | Zip |

**EXPLANATION:**

* UnityPoint Health and its affiliates (“UPH”) may communicate with your family members and friends who are involved in your care or payment for your care in accordance with UPH Affiliated Covered Entity’s Notice of Privacy Practices. In this section, you may list specific individuals who are involved with your care or payment for your care and with whom UPH may communicate.
* By signing below, you agree that UPH may share with the below-listed individuals your medical information which may include information related to mental health, substance use disorder (including that covered by 42 CFR Part 2), genetic information, and/or HIV (“sensitive information”) to assist them in caring for you or paying for your care. This sensitive information may include without limitation diagnosis, treatment, medications, interventions, drug screening, urine toxicology, and assessments about your specific condition. However, only information from your medical record directly relevant to your care or payment for your care will be shared.
* In addition to those individuals you list below, UPH may also communicate your non-sensitive health information with family and friends involved in your care or payment for my care even if they are not listed below, as long as you do not object. If you are incapable of objecting or unavailable, UPH may use its professional judgement in deciding with whom to communicate as allowed under law and with whom communicating is in your best interest. However, only information directly relevant to your care or payment for your care will be shared. In addition, *UPH will not share sensitive information with individuals not listed below unless allowed by law.*
* UPH is not required to contact any of the below-listed individuals. Nor is UPH obligated to contact all of the below-listed individuals.
* **Note:** The individuals listed below do not have any authority to make treatment or care decisions for you. If you wish to designate a health care representative through a Durable Power of Attorney for Health Care, or if you wish to set up a living will, please discuss this with your primary healthcare clinician or your attorney. In addition, you may need to complete a separate authorization to allow UPH to release written medical records to your family members or friends.

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|  |  |  |  |  |  |  | Does contact need an interpreter?  If yes, check box. |
|  |  |  |  |  |  |  |  |
| Contact Name |  | Relationship |  | Phone Number |  | Contact’s Primary Language  (if not English) |  |
|  |  |  |  |  |  |  |  |
| Contact Name |  | Relationship |  | Phone Number |  | Contact’s Primary Language  (if not English) |  |
|  |  |  |  |  |  |  |  |
| Contact Name |  | Relationship |  | Phone Number |  | Contact’s Primary Language  (if not English) |  |
|  |  |  |  |  |  |  |  |
| Contact Name |  | Relationship |  | Phone Number |  | Contact’s Primary Language  (if not English) |  |

**IF NO NAMES ARE LISTED ABOVE, PLEASE INDICATE DECLINATION:**

I do not wish to add friends or family to this form. However, I understand that UPH may still communicate with family and friends involved in my care or payment for my care even if they are not listed above, as long as I do not object or, if I am incapable of objecting or unavailable, UPH may use its professional judgement in deciding with whom to communicate as allowed under law. However, *UPH will not share sensitive information with individuals unless they are specifically listed above or unless allowed by law.*

I understand that it is my responsibility to update the above information if I want it changed. I understand that individuals receiving my health information pursuant to this form may share the information with others, and state and federal privacy laws may not protect it. I understand that I retain the right to inspect and ask for a copy of any information related to these communications as permitted by law.

This form will be in effect for a period of three (3) years from signature unless sooner revoked or replaced by a new form. I may be asked to confirm the information with a new dated signature on an annual basis. Any revision or revocation shall be made in writing by completing a new form to include my signature and date of completion. I may revoke my consent at any time in writing. If I revoke my consent, I understand that my revocation will not apply to any uses and releases of my health information already made by UPH before I changed my consent. If I refuse to consent, I understand that UPH may not be able to contact or coordinate my care with my friends and family members.

**By signing below, I understand and consent to have UPH communicate with others as described above.**

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| Patient or Legally Authorized Representative Signature | Date | Time |
|  |  | |
| Patient Representative Printed Name | Relationship to Patient (if not patient) | |

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| **For Staff Use:**  Family members and friends receiving substance use disorder information shall be advised as follows: “This record which has been disclosed to you is protected by federal confidentiality rules ([42 CFR part 2](https://www.ecfr.gov/current/title-42/part-2)). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by [42 CFR part 2](https://www.ecfr.gov/current/title-42/part-2).” |