HONORHEALTH®

Confidential Communications Form

This form helps us understand how you want us to communicate with you, or others, about the care we provide you. You can choose what modes of communication you would like us to use and who we can share information with. We may need to communicate test results, prescription information or respond to a message you left with your physician's office. By completing this form, you understand the following:

- This form gives us permission to communicate with you in a manner that you choose.
- You can change your decisions on this form at any time by completing a new form. We cannot change information on this form over the phone. If you want anything changed on this form, it is your responsibility to contact us to complete a new form. You will be asked to review or update this form at least annually on your next visit to our office.
- If you give us permission to communicate your health information to someone else, you understand that this could include any information in your medical record including test results, medications, diagnoses, procedures, etc.
- You understand that your decisions on this form apply to communications made to or from HonorHealth physician offices and not in other locations within HonorHealth (e.g., inpatient hospital).
- You have received a copy of HonorHealth's *Notice of Privacy Practices* and understand other ways HonorHealth can use or disclose your health information not otherwise listed on this form.

Patient Name: _____ MRN: _____

Please tell us how you would like us to communicate information to you by checking all the boxes that apply:

☐ You may contact me by telephone/text/voice mail: **Cell** ☐ **Home** ☐ (_____) _____ - _____

☐ You may contact me by e-mail. E-mail address: _____

Please list the name(s) of the person(s) below who you give us permission to communicate your health information and the kind of information you permit us to communicate:

Name and Phone Number	This person's relationship to you	Information we can share (check box)
		☐ Billing information ☐ Appointment information ☐ Medical information
		☐ Billing information ☐ Appointment information ☐ Medical information
		☐ Billing information ☐ Appointment information ☐ Medical information

By signing below, you allow us to communicate your health information to you and permit us to share your health information with other persons, as indicated above. <u>Please bring this form to your physician office to have it uploaded to your medical record for reference</u>. This form cannot be received by email or fax.

Patient Name (Please Print)	Patient Signature	Date of Signature
Patient's Legal Representative (if patient can't sign) (Please Print Name)	Patient's Legal Representative Signature	Date of Patient's Legal Representative Signature