



Ball Memorial Physicians

Authorization to Release Confidential Information to Other Persons and/or Leave Messages

Patient Label

PREFERRED COMMUNICATION LIST

In caring for our patients, it may be necessary to contact you by telephone. If you are not available when we call, we would like to be able to leave telephone messages when possible. There are also times where you may want us to communicate labs, medication, treatment plans, or billing information to a trusted friend or family member. In order to protect your privacy, we need your written permission to leave messages on the phone or with another person you designate concerning you or your child's treatment and health care.

WAYS IU HEALTH CAN COMMUNICATE WITH YOU ABOUT YOU OR YOUR CHILD

If we are unable to reach you directly to communicate medical information concerning you or your child, how would you like to receive health information? **Please check all that apply:**

☐ **I DO PERMIT** IU Health to leave voice mail at the following numbers listed below:

Preferred phone #1 _____ Name _____ Relation to patient: _____

Preferred phone #2 _____ Name _____ Relation to patient: _____

☐ **I DO NOT PERMIT** IU Health to leave voice mail on my phone.

FAMILY AND FRIENDS COMMUNICATION

I give approval for IU Health staff to speak with designated family or friends concerning my or my child's treatment and health care. If yes, please complete the **Family and Friends Communication** section of this form with names of individuals IU Health is able to communicate with on your behalf.

☐ Yes

☐ No

IU Health will not release any information on voice mail or to family or friends regarding HIV, sexually transmitted diseases, pregnancy tests or contraceptive counseling. This information will be released only to the patient and to any public health agency to which IU Health is legally bound to report such information, unless otherwise permitted by law.

IU Health is committed to ensuring the privacy and security of patient health information. Reasonable steps will be taken to give you, as our patient, an opportunity to agree or object to the release of specific medical information. I understand this permission is valid until revoked by me. I understand that if I choose to revoke this authentication, I must do so in writing and provide to the office staff at this practice.



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INFORMATION TO OTHER PERSONS AND/OR
LEAVE MESSAGES**

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Other Consent

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Patient Name

Date of Birth

Patient/Guardian Signature

Guardian Printed Name

Date

FAMILY AND FRIENDS COMMUNICATION

I permit IU Health to communicate with family and friends identified below who are involved with my health care or payment the following relevant information about me or my child. I understand that this information may be subject to re-disclosure by my family and friends and that the disclosed information is then beyond the privacy protection of IU Health. IU Health will not release any information regarding HIV, sexually transmitted diseases, pregnancy tests or contraceptive counseling.

Authorized Individual

Phone Number

Relationship to Patient

The above-named person may receive the following information about my treatment and healthcare (Please check all that apply):

- ☐ Any and all information
- ☐ Information necessary to schedule, confirm, cancel, or reschedule appointments
- ☐ Information about test results
- ☐ Information about prescriptions/prescription pick-up
- ☐ Information about my bills or account

Authorized Individual

Phone Number

Relationship to Patient

The above-named person may receive the following information about my treatment and healthcare (Please check all that apply):

- ☐ Any and all information
- ☐ Information necessary to schedule, confirm, cancel, or reschedule appointments
- ☐ Information about test results
- ☐ Information about prescriptions/prescription pick-up
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Other Consent

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Authorized Individual

Phone Number

Relationship to Patient

The above-named person may receive the following information about my treatment and healthcare
(Please check all that apply):

- ☐ Any and all information
- ☐ Information necessary to schedule, confirm, cancel, or reschedule appointments
- ☐ Information about test results
- ☐ Information about prescriptions/prescription pick-up
- ☐ Information about my bills or account

Patient/Guardian initials: _____

Date: _____

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