Communication Consent

Name – Last, First, MI	Medical Record Number	Date of Birth:

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), the Communication Consent identifies who you allow Mile Bluff Medical Center, Inc to communicate with on your behalf. These communications may occur when the identified person(s) joins you at your visit or contacts us by telephone (including leaving voicemail), email, or other electronic methods.

This is especially helpful in case there is an urgent need to contact you regarding your appointment management, diagnoses, results, or medication follow-up. This may also include anyone who may assist you with your finances.

The type of information disclosed could include medical history of diagnostic and therapeutic information, including information regarding mental health, developmental disability, HIV, and substance use disorder, unless specified below.

Section A. Sensitive Communications

☐ I decline to receive detailed voice messages from Mile Bluff Medical Center, Inc

☐ I give Mile Bluff Medical Center, Inc permission to leave detailed voice messages regarding:

☐ Medical Information, including diagnoses, results, and treatment plans

Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV

Other: _____

☐ Appointment Management, including scheduling, cancelling, and rescheduling of appointments

Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV

Other: _____

Preferred phone number where messages can be left: _____ ☐ Home ☐ Cell ☐ Work

Section B. Permitted Disclosures

☐ I decline any communication to others outside of myself/legal guardian(s).

☐ I give permission for Mile Bluff Medical Center, Inc to communicate with the following person(s) regarding:

Name: _____ Relationship: _____ Verbal Only: _____

Phone: _____ Address: _____

This Person May Receive Information Related to:

☐ Medical Information, including diagnoses, results, and treatment plans

Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV

Other: _____

☐ Appointment Management, including scheduling, cancelling, and rescheduling of appointments

Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV

Other: _____

☐ My Billing and Payment Information

Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV

Other: _____

Name: _____ Relationship:_____ Verbal Only:_____

Phone: _____ Address:_____

This Person May Receive Information Related to:

☐ Medical Information, including diagnoses, results, and treatment plans
Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV
Other: _____

☐ Appointment Management, including scheduling, cancelling, and rescheduling of appointments
Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV
Other: _____

☐ My Billing and Payment Information
Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV
Other: _____

Name: _____ Relationship:_____ Verbal Only:_____

Phone: _____ Address:_____

This Person May Receive Information Related to:

☐ Medical Information, including diagnoses, results, and treatment plans
Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV
Other: _____

☐ Appointment Management, including scheduling, cancelling, and rescheduling of appointments
Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV
Other: _____

☐ My Billing and Payment Information
Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV
Other: _____

Name: _____ Relationship:_____ Verbal Only:_____

Phone: _____ Address:_____

This Person May Receive Information Related to:

☐ Medical Information, including diagnoses, results, and treatment plans
Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV
Other: _____

☐ Appointment Management, including scheduling, cancelling, and rescheduling of appointments
Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV
Other: _____

☐ My Billing and Payment Information
Excluding: ☐ Behavioral Health ☐ Developmental Disability ☐ Substance use disorder ☐ HIV
Other: _____

Section C. Billing, Payment and Collection Communications

(Telephone Consumer Protection Act (TCPA) Consent)

☐ I decline to receive automated telephone and/or text messages from Mile Bluff Medical Center, Inc regarding my billing, payment and collection information.

☐ I hereby authorize Mile Bluff Medical Center, Inc., its Affiliates, and its Business Associates (including third parties and third-party debt collectors) to contact me for various purposes associated with my account, including but not limited to, collection of payment for services rendered. I further consent to the use of automated dialing equipment, prerecorded voice, or text messages delivered to the current or future numbers and email addresses I provide to Mile Bluff Medical Center, Inc.

I understand that:

- I am not required to grant consent as a condition of purchasing health care goods and services from Mile Bluff Medical Center, Inc.
- I may revoke my consent at any time by contacting Mile Bluff Medical Center, Inc at 608-847-1855
- If my contact information changes, I agree to promptly inform Mile Bluff Medical Center, Inc at 608-847-1855
- Standard messaging rates may apply to any such communications from Mile Bluff Medical Center, Inc

Preferred phone number where messages can be left or sent:

_____ ☐ Home ☐ Cell ☐ Work

This Communication Consent is in effect until changed or revoked by me. Only I can change who is named on this form to communicate with Mile Bluff Medical Center, Inc about my health or billing information. At the time of change or revocation, a new form will be completed by me. Emergency contacts are not included in this consent.

I understand that to release copies of my medical or billing records, this requires a specific authorization form signed by me or my legal representative.

Signature: _____ Date: _____

If signed by someone other than the patient:

☐Parent of Minor ☐ Legal Guardian ☐Next of Kin ☐Health Care Agent

☐Personal Representative ☐ Other

Revised: 3/26