Attachment 1

Patient Name _____

The University of ALABAMA

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.

	METHOD	NUMBER/ADDRESS	MESSAGES (YES OR NO)
____	Home Phone	(____) _____	☐ Yes ☐ No
____	Cell Phone	(____) _____	☐ Yes ☐ No
____	Work Phone	(____) _____	☐ Yes ☐ No
____	Alternate phone	(____)_____	☐ Yes ☐ No
____	Text Messages	(____)_____	
____	Email	_____	
____	Patient Portal		

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 my choice to be a "No Information" and I do not want any information released to anyone else.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFO
_____		
_____		
_____		

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, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that UMC may impose.

_____

Patient Name printed Date

Patient/Authorized signature Relationship to patient

Created: 4/3/2003

Revised: 6/8/2012