Patient Name: ___________________________________

Date of Birth: _________________________

ALTERNATIVE COMMUNICATIONS REQUEST FORM

This is a consent for UnityPoint Clinic® – Pediatrics to share information to the below named person/people regarding appointments or status by phone, face to face or in writing. I understand that I do not have to choose anyone and I understand that none of my information may be shared without my consent.

I give my permission to UnityPoint Clinic to communicate information concerning my medical condition and medical treatment to the person(s) listed below.

____

(Name) (Relationship)

____

(Name) (Relationship)

I understand that it is my responsibility to update the above information if I want it changed. This communication information will be used for medical conditions and treatment obtained at UnityPoint Clinic or at the request of one of the physicians employed at UnityPoint Clinic.

I understand that Mental Health, substance abuse treatment and /or HIV information may not be disclosed pursuant to this form and that HIPPA-compliant Patient Authorization to Release Information form must be completed to disclose any mental health, substance abuse and/or HIV information. Additionally, I understand that if there are expectations to the communications permitted pursuant to this form, it is my responsibility to notify UnityPoint Clinic.

This consent will be in effect until revoked by me in writing.

____ ________________________

(Patient **Printed** Name) (Patient Date of Birth)

____ ________________________

(Patient Signature) (Date signed)