Request for Alternative Means or Locations of Communication

UnityPoint Clinic

The purpose of this form is to obtain guidance from you (the patient) about how we should communicate about you and to you.

Patient Information

Date of Request: _____ / _____ / _____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Patient Address: _____

City State Zip

SECTION 1: Communications to Family Members and Others Involved In My Healthcare

I give my permission to UnityPoint Clinic to communicate information concerning my medical condition and medical treatment to the person(s) listed below. ***(Note: If the patient is a minor, pursuant to Iowa and Illinois law, information generally will be given to both parents unless UnityPoint Clinic otherwise deems the communication inappropriate.)***

Name 1: _____ _____ _____
Relationship Phone No.

Name 2: _____ _____ _____
Relationship Phone No.

Name 3: _____ _____ _____
Relationship Phone No.

I understand that it is my responsibility to update the above information if I want it changed. This communication information will be used for all 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 a HIPAA-compliant Patient Authorization to Release Information form must be completed to disclose any mental health, substance abuse treatment and/or HIV information. Additionally, I understand that if there are exceptions to the communications permitted pursuant to this form, it is my responsibility to notify UnityPoint Clinic.

Note: This form does not provide the above-named person(s) with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner or representative, or if you wish to set up a living will, please discuss this with your primary healthcare physician or your attorney.

SECTION 2: Standard Methods to Communicate to Me (the patient)

Detailed information regarding my medical condition and medical treatment may be left on:

My Home Answering Machine	☐ Yes	☐ No	Home no. is: _____
My Work Answering Machine	☐ Yes	☐ No	Work no. is: _____
My Cell Phone	☐ Yes	☐ No	Cell no. is: _____

Text Messages ☐ Yes ☐ No Cell no. is: _____

(Standard text message rates may apply; only appointment reminders will be sent by text message.)

Exceptions (types of information that cannot be left as messages): _____

_____

SECTION 3: Request for Alternative Communications to Me (the patient)

This section is required ONLY to indicate alternative communications to phone numbers and addresses other than my contact information listed above.

I request UnityPoint Clinic to contact me in the following manner:

☐ Telephone communication at the following telephone number: _____

☐ Correspondence to be sent to the following address: _____

_____

I understand that UnityPoint Clinic may not require me to provide a reason for this request as a condition for accommodating this request. However, UnityPoint Clinic may condition its acceptance of these conditions upon my providing sufficient information for billing purposes or upon my providing an alternative address or other method of contacting me.

For UnityPoint Clinic Use Only:

☐ *Accepted Request for Alternative Communication*

☐ *Denied Request for Alternative Communication due to:* _____

_____

Approved by: _____

Clinic Administrator or Designee

This form will be in effect until revoked, but I may be asked to confirm the information with a new dated signature on an annual basis.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Relationship (if not patient)