Please fax to 303-398-1211, or mail to National Jewish Health, HIM Dept, Rm L07, 1400 Jackson St, Denver, CO 80206

In our Notice of Privacy Practices, we informed you that we might share your protected health information verbally to those individuals involved in your care or payment for your care.

By completing this form, you may designate those individuals with whom we may discuss your routine health information such as lab results, future appointments and/or billing related questions.

1. **Patient: When is it okay to leave you a message about your health information?** (We will try to contact you directly if we have urgent or sensitive information.)
   - ☐ Never
   - ☐ On my voicemail at home #____________________
   - ☐ On my voicemail at work #____________________
   - ☐ On my voicemail on mobile phone #____________________

2. **Alternate Patient Representative: With whom may we discuss your health information?** (Please remember this does not apply to calls made from our automated appointment reminder system to your phone number unless you request that we discontinue this service.)
   - ☐ No one
   - ☐ The people listed below:

Name	Relationship	Phone Number

3. **Content of Disclosure Preference: We will leave a message including detailed personal medical information unless otherwise specified below:** (Please indicate below the types of information about which you do not want us to leave a message.)

   ____

4. **Pediatric Patients Third Party Preferences: May we communicate with your child's school, daycare or childcare provider about your child's health care?** ☐ Yes ☐ No

This consent will remain in effect until revoked by the patient/representative or when the minor patient reaches the age of majority or becomes emancipated. Please notify us of any changes.

____
Patient's Name for Initial Preference Designation Date of Birth

____
Signature of Patient/Legal Personal Representative Date/Time

Revocation of Communication Preferences Listed Above (Preferences Changes ONLY):
Revoke all preferences? ☐ Yes Change preferences? ☐ Yes. Indicate changes below:

____

____
Signature of Patient/ Legal Personal Representative Date/Time

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HIPAA Patient Request _CC

Patient label