Patient Label

National Jewish Health
Breathing Science is Life.

Consent to Communicate Personal Health Information

In our Notice of Privacy Practices, we informed you that we may disclose your protected health information to those individuals that you identify. By completing this form, you can identify those individuals with whom we can discuss your routine health information such as lab results and future appointments.

1. **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. **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
Name	Relationship	Phone Number

3. **We will leave a message including <u>detailed personal medical information</u> except about the following topics:** (Please indicate below the types of information about which you do <u>not</u> want us to leave a message.)

_____

4. **For Pediatric Patients: may we communicate with your child's school, daycare or child care 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.

This form does not apply to psychotherapy notes as defined by the Privacy Rule *45 CFR 164.501.***. (for release of pediatric psychosocial health information, use PBH-016; for release of adult psychotherapy notes, use HIP-008)**

Patient's name _____ Date of Birth _____

Signature of Patient, Parent or Authorized Personal Representative _____ Date _____

Use this section to change preferences:

Revoke all preferences? ☐ Yes
Change preferences? ☐ Yes. Indicate changes below.

_____

Signature of Patient, Parent or Authorized Personal Representative _____ Date _____

Please fax to 303-398-1987, or mail to National Jewish Health, HIM Dept, Rm L07, 1400 Jackson St, Denver, CO 80206