UCONN HEALTH

UConn John Dempsey Hospital
UConn Medical Group
UConn School of Dental Medicine

(Patient Identification)

## Permission to Communicate Health Information and Use Alternative Communication Methods

**Permission to Communicate**:
I acknowledge that by signing this form, I give UConn Health permission to communicate about my care (including my protected health information (PHI)), with the family member, friend, or other individual named below.

UConn Health may discuss my care, including my PHI, with:

Name: _____
Relationship to you: _____
Phone number (mobile preferred): _____

**Request to Use Alternative Methods of Communication**:
I may also use this form to give UConn Health permission to communicate with me and the person named above using alternative methods of communication (mail, email, text, voicemail).

UConn Health may use the following when communicating with me and the person named above (check all that apply):

Mail ☐ with me, using mailing address:_____
☐ with the person named above, using mailing address:_____
Email ☐ with me, using email address:_____
☐ with the person named above, using email address: _____
Text ☐ with me, using the number: _____
☐ with the person named above, using the number: _____
Voicemail ☐ with me, using the number: _____
☐ with the person named above, using the number: _____

I acknowledge that email and text messaging are not completely secure means of communication. I also acknowledge that detailed voice messages allow clinicians to provide important medical information to me in a timely manner, but if the voicemail system is shared, this information may be heard by others.

Printed Name_____

Signature _____ Date_____ Time _____