SURGICAL ASSOCIATES MANSFIELD

Methodist MEDICAL GROUP

Patient Preference Regarding Communication of Health Information

In order to better protect your privacy under HIPAA, we have created this consent form for releasing medical information to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the phone numbers listed below, mail your lab results to your home and also send secure email results to your personal email address once enrolled in MyChart. We are legally not allowed to release medical information to patient family members without the patient's written consent. The purpose of this document is to protect your privacy.

Communication to Family Members, Spouses or Other:

I authorize Methodist Medical Group (MMG)/ Surgical Associates of Mansfield (SAM) and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Emergency Contact Only: Name: _____ Relation: _____ Phone: _____

Communication for Appointment Reminders and Appointment Follow-Ups:

Methodist Medical Group (MMG)/ Surgical Associates of Mansfield (SAM) may need to use your name, phone number, email address ("Contact Information"), and your clinical records to contact you with appointment reminders and information about treatment alternatives. If this communication is made by phone and you are not available, a message will be left on your voice mail or with the person answering the phone. By signing this form, you are consenting for Surgical Associates of Mansfield (SAM) to contact you with appointment reminders and information and to leave messages on a voice mail or with individuals at you home. Information that we use or disclose based on this consent may be subject to re-disclosure by anyone who has access to the reminder and my no longer be protected by federal privacy rules.

You have the right to refuse to give Methodist Medical Group (MMG)/ Surgical Associates of Mansfield (SAM) your consent to use your telephone number and/or email address for appointment reminders and treatment alternatives. If you chose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give Surgical Associates of Mansfield (SAM) this consent or revoke it in the future, it will not affect the treatment we provide to you.

I CONSENT to the following forms of communication for appointment reminders and follow-up communication (*please initial all that apply*): ____ email address _____ phone number _____ text message[1] _____ secure patient portal to be used in the manner described above.
Preferred Email Address _____ Preferred Telephone Number _____

If you consented to communication via the secure patient portal, you will be notified via email when there is secure information for you to review such as lab results. The email will provide a link that you will use to access the secure website. After clicking on the link, you will be required to log-in and provide your unique user name and password.

In choosing your email address, please consider privacy implications; for example, any other person that may have access to your email or any other person, such as your employer, that may have the right and/ or ability to review all email received at your work address.

___ (initial) I decline to give Methodist Medical Group (MMG)/ Surgical Associates of Mansfield (SAM) consent to use my Contact Information and clinical records to contact me with appointment reminders and information about treatment alternatives. I understand I may be required to schedule a follow up appointment with the doctor for review my test results or it could take up to 10 business days to receive your results in the mail.

Consent and Agreement: I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information.

_____ _____

Signature of Patient or Guardian Date

[1] Please note the text messaging service is a complimentary service provided by TOSS, but standard messaging rates from your wireless carrier may still apply. If you have questions, please contact your wireless carrier.