Perinatal Center Patient Communication Form

Name: _____ DOB: _____ Last 4 digits of SSN: _____

The purpose of this form is to obtain guidance about how we should communicate about you and to you.

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

I give my permission to Perinatal Center 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 law, information generally Will be given to both parents unless Perinatal Center otherwise deem the communication inappropriate.)

Name 1: _____ Relationship: _____ Phone: _____

Name 1: _____ Relationship: _____ Phone: _____

Name 1: _____ Relationship: _____ Phone: _____

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 Perinatal Center or at the request of one of the healthcare providers employed at Perinatal Center. 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 Perinatal Center.

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 number is: _____

My Work Answering Machine ☐ Yes ☐ No Work number is: _____

My Cell Phone ☐ Yes ☐ No Cell number is: _____

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

_____

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): _____