A Northside Network Provider

English - Spanish - French - Korean - Simplified Chinese - Vietnamese

[OPTIONAL FORM – NOT REQUIRED TO BE COMPLETED]

AFFIX PATIENT LABEL HERE

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____ Date: _____

Federal law allows a health care provider to discuss your health information related to your care or payment for your care with your family members and close personal friends who are involved in your care if you authorize us to do so. This form allows you to designate family members, friends or others with whom the practice listed above can share your health information and communicate with about your health care.

By signing below, you understand and acknowledge the following:

- The practice listed above is authorized to discuss your health information with the individuals that you have listed on this form.
- This form does not restrict a healthcare provider from discussing your health information with individuals not listed on this form if such discussions are permitted by law.
- This form authorizes the practice to verbally communicate with the individuals you have listed below but does not entitle them to obtain copies of your medical records.
- This form applies only to the practice listed above. If you receive health care from other Northside affiliated medical practices, you will need to complete a new form for each practice.
- This form is entirely voluntary and optional. Electing not to complete this form will not impact your care provided at this practice.

This form can be revoked by submitting a written request to the physician practice identified at the top of this form. You have the right to revoke this form in writing at any time except to the extent action has already been taken in reliance on it. The consent remains in effect until you expressly revoke it in writing. Completing a new Consent to Communicate form or electronically changing your communication preferences does not revoke any previous Consent to Communicate forms that you have completed, which the Practice may continue to rely on unless you elect to revoke the form.

First and Last Name:	Relationship:

_____ _____

Witness Date/Time Signature of Patient or Legal Representative Date/Time

_____

Relationship to Patient If Not the Patient

_____ _____

Interpreter Signature Date/Time Reason Patient Unable to Sign

Note: If phone/video interpretation used, record interpreter ID#

Interpreter comments (optional): _____

_____

Please complete this form and return it to the Practice

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NORTHSIDE HOSPITAL PHYSICIAN OFFICE PRACTICE
CONSENT TO COMMUNICATE WITH DESIGNATED INDIVIDUALS