Consent to Communicate

Person-to-Person Communication

My care team may discuss detailed information with the people I have listed about the topics I have marked.

1. _____ _____ _____
   First and Last Name (please print) Relationship to patient Best contact number
   Please share information about: ☐ Scheduling ☐ Medical ☐ Billing ☐ Items to pick up

2. _____ _____ _____
   First and Last Name (please print) Relationship to patient Best contact number
   Please share information about: ☐ Scheduling ☐ Medical ☐ Billing ☐ Items to pick up

3. _____ _____ _____
   First and Last Name (please print) Relationship to patient Best contact number
   Please share information about: ☐ Scheduling ☐ Medical ☐ Billing ☐ Items to pick up

Do not share information about: ☐ Mental health ☐ Chemical dependency ☐ Infectious Diseases
☐ Other: _____

I understand that:

- This form applies to Fairview Health Services, HealthEast facilities and services, Range Regional Health Services, Grand Itasca Clinic and Hospital, M Health Fairview, and University of Minnesota Physicians and to the information in the common electronic health record used by these organizations, as well as other clinics. These are listed at https://www.fairview.org/patient-resources/medical-records/electronic-health-records.
- This form **does not** grant access to my medical records (including copies) **or** any involvement in my health care decisions. If I want to allow such involvement, I must grant permission in a healthcare directive or other legal appointment and fill out a separate consent form.
- This form does not expire (no end date). To change the information on this form or add or remove designated people, I must fill out a new form.
- Once my information is shared with the person(s) named above, it may no longer be protected by privacy laws. We cannot prevent these persons from sharing my information with a third party.
- I will still be treated, even if I do not sign this form.

✍ _____ _____ _____
Signature of Patient or Authorized Decision-Maker Printed Name Date and Time

Authorized Decision-Maker's reason for signing: ☐ Parent or legal guardian of a minor child.
☐ Family member (spouse, adult child, parent, or adult sibling). ☐ Court-appointed legal guardian of an adult.
☐ Patient-appointed proxy in a Psychiatric Directive. ☐ Health care agent appointed in a Health Care Directive.

For staff only, if an interpreter was used during the consent process:

_____ _____
Interpreter Printed Name or ID# (if accessed by phone or video) Employer/Organization

_____ _____
Language Date and Time