THE UNIVERSITY OF KANSAS HEALTH SYSTEM

4000 Cambridge Street
Kansas City, Kansas 66160

Do not write in this box

Patient Auth to Share/Leave Med Info

Name:______________________________

DOB:______________________________

MR#______________________________

Department Name:______________________________

# PATIENT PERMISSION TO COMMUNICATE INFORMATION WITH DESIGNATED INDIVIDUALS

The physicians and staff of the department named above know that communicating with you about your healthcare is important. By completing this form, you give us permission to provide messages and/or discuss information about your healthcare with the individuals designated below.

1. I agree to allow the physicians and staff of the department named above to discuss relevant medical, billing, and insurance information with the individuals listed below (example: spouse, relatives, friend). I understand that my healthcare provider will use professional judgment to determine what information about my healthcare may be discussed with the designated individuals below:

   Name ____________________ Relationship____________________ Phone Number ____________________
   Name ____________________ Relationship____________________ Phone Number ____________________
   Name ____________________ Relationship____________________ Phone Number ____________________

   ______Please do not discuss my medical information with anyone other than myself. I understand that checking this does not prevent my healthcare provider from disclosing my medical or billing information as may be otherwise allowed under state and federal privacy law.

2. I authorize the physicians and staff of the department named above to leave/send messages about scheduling, treatment, surgery, lab or radiology results, insurance and billing, transplant information, or other information regarding my care as follows:

   ***Please check yes or no:***

   Cell phone ☐ Yes ☐ No
   Home Phone ☐ Yes ☐ No
   Work Phone ☐ Yes ☐ No

   ***Please select one of the following:***

   ___ Authorization expires:________________________
   (Date)
   ___ No expiration
   ___ Expires on patient's 18th birthday

I understand that I may cancel or change this authorization at any time by providing a written request to the department named above.

__________________________________________________
Signature of Patient or Authorizing Person:

__________________________________________________
Printed Name of Authorizing Person:

__________________________________________________
Relationship to Patient:

__________________ __________________
Today's Date Time

Interpreter required: ☐ YES ☐ NO

Mode of Interpretation
☐ Sight Translated ☐ Interpreted

Signature of Interpreter: ______________________________

Interpreter's Printed Name:______________________________

__________________ __________________
Today's Date Time

Consent must be signed by the patient, by a parent if the patient is a minor, or by a guardian if the patient is incapacitated and by the certified medical interpreter, if applicable

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