emplify HEALTH

COMMUNICATION CONSENT

Patient Name: _____ Medical Record Number: _____ Date of Birth: _____

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), the Communication Consent identifies who you allow Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd. to communicate with on your behalf. These communications may occur when the identified person(s) joins you at your visit or contacts us by telephone (including leaving voicemail), email, or other electronic methods.

This is especially helpful in the case there is an urgent need to contact you regarding your appointment management, diagnoses, results, or medication follow-up. This may also include anyone who may assist you with your finances.

The type of information disclosed could include: medical history of diagnostic and therapeutic information, including information regarding mental health, developmental disability, HIV, and substance use disorder, unless specified below.

Section A. Sensitive Communications

☐ I decline to receive detailed voice messages from Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd.
☐ I give Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd. permission to leave detailed voice messages regarding:
- ☐ Medical Information, including diagnoses, results, and treatment plans
  Excluding: ☐Behavioral Health ☐Developmental Disability ☐Substance use disorder ☐HIV ☐Other: _____
- ☐ Appointment Management, including scheduling, cancelling, and rescheduling of appointments
  Excluding: ☐Behavioral Health ☐Developmental Disability ☐Substance use disorder ☐HIV ☐Other: _____

Preferred phone number where messages can be left: _____ ☐Home ☐Cell ☐Work

Section B. Permitted Disclosures

☐ I decline any communication to others outside of myself/legal guardian(s).
☐ I give permission for Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd. to communicate with the following person(s) regarding:

Name: _____ Relationship:_____ Phone: _____
This Person May Receive Information Related to: ☐Home ☐Cell ☐Work

- ☐Medical Information, including diagnoses, results, and treatment plans
  Excluding: ☐Behavioral Health ☐Developmental Disability ☐Substance use disorder ☐HIV ☐Other: _____
- ☐Appointment Management, including scheduling, cancelling, and rescheduling of appointments
  Excluding: ☐Behavioral Health ☐Developmental Disability ☐Substance use disorder ☐HIV ☐Other: _____
- ☐My Billing and Payment Information
  Excluding: ☐Behavioral Health ☐Developmental Disability ☐Substance use disorder ☐HIV ☐Other: _____

Name: _____ Relationship: _____ Phone: _____
This Person May Receive Information Related to: ☐Home ☐Cell ☐Work

- ☐Medical Information, including diagnoses, results, and treatment plans
  Excluding: ☐Behavioral Health ☐Developmental Disability ☐Substance use disorder ☐HIV ☐Other: _____
- ☐Appointment Management, including scheduling, cancelling, and rescheduling of appointments
  Excluding: ☐Behavioral Health ☐Developmental Disability ☐Substance use disorder ☐HIV ☐Other: _____
- ☐My Billing and Payment Information
  Excluding: ☐Behavioral Health ☐Developmental Disability ☐Substance use disorder ☐HIV ☐Other: _____

Name: _____ Relationship: _____ Phone: _____
This Person May Receive Information Related to: ☐Home ☐Cell ☐Work

- ☐Medical Information, including diagnoses, results, and treatment plans
  Excluding: ☐Behavioral Health ☐Developmental Disability ☐Substance use disorder ☐HIV ☐Other: _____
- ☐Appointment Management, including scheduling, cancelling, and rescheduling of appointments
  Excluding: ☐Behavioral Health ☐Developmental Disability ☐Substance use disorder ☐HIV ☐Other: _____
- ☐My Billing and Payment Information
  Excluding: ☐Behavioral Health ☐Developmental Disability ☐Substance use disorder ☐HIV ☐Other: _____

Section C. Billing, Payment and Collection Communications (Telephone Consumer Protection Act (TCPA) Consent)

☐ I decline to receive automated telephone and/or text messages from Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd. regarding my billing, payment and collection information.

☐ I give Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd. permission to leave automated telephone and/or text messages regarding my billing, payment and collection information.

By signing below, I hereby authorize Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd., its Affiliates, and its Business Associates (including third parties and third-party debt collectors) to contact me for various purposes associated with my account, including but not limited to, collection of payment for services rendered. I further consent to the use of automated dialing equipment, prerecorded voice, or text messages delivered to the current or future numbers and email addresses I provide to Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd..

I understand that:

- I am not required to grant consent as a condition of purchasing health care goods and services from Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd.
- I may revoke my consent at any time by contacting Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd. at 608-782-7300
- If my contact information changes, I agree to promptly inform Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd. at 608-782-7300
- Standard messaging rates may apply to any such communications from Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd.

Preferred phone number where messages can be left or sent: _____ ☐Home ☐Cell ☐Work

This Communication Consent is in effect until changed or revoked by me. Only I can change who is named on this form to communicate with Gundersen Lutheran Medical Center, Inc / Gundersen Clinic Ltd. about my health or billing information. At the time of change or revocation, a new form will be completed by me. Emergency contacts are not included in this consent.

I understand that to release copies of my medical or billing records, this requires a specific authorization form signed by me or my legal representative.

Signature: _____ Date: _____

If signed by someone other than the patient: ☐Parent/Legal Representative ☐Health Care Agent (Health Care Power of Attorney)