**Yale Health**

**Authorization for Communication and Alternate Communication Methods**

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the family member or friend named below to have authority to access to my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below. If I choose, I may also use this form to indicate my interest in using alternative communication methods (voice mail, email, texting).

**Patient Information – Please Print and Return to Yale Health Member Services**

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

Authorized Individual **- Please Print**

Name: _____

Address: _____

Phone Number:_____ Relationship to Patient: _____

**I grant to the individual named above access to:**

___All of my PHI – *note separate box below is also required for HIV, psychiatric and substance abuse access.*

___Other - Specify limits or specific health care incident_____

By checking the appropriate categories and by signing this box I (patient) am granting my HIPAA Representative access to additional health information:

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this box, I am specifically authorizing my HIPAA Representative access to information relating to:

__ Substance Abuse (including alcohol/drug abuse)
__ Mental Health
__ Psychotherapy Notes
__ HIV related information (including AIDS related testing)

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Signature of Patient for this box: _____ Date: _____

**Use of email, text messaging, voice mail**

Email and text messaging allows health care providers to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission. Similarly, detailed voice mail messages allow clinicians to provide test results, medical and referral information to you in a timely manner but if the voice mail system is shared, the information could be heard by others.

We recommend that our patients sign up for our patient portal, MyChart, which allows secure communication with your caregiver team.

If you would like us to send you email and/or text messages or leave detailed voice mails that contains your health information, please check the appropriate boxes and sign this Consent below. You are not required to authorize the use of email, voice mail and/or text messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email, voice mail and/or text messaging we will continue to use U.S. Mail or telephone to communicate with you.

I authorize the use of the following communication methods when communicating with me and my authorized individual (check all that apply):

☐ E-mail address that may be used to send information to YOU:_____

☐ Phone number of text messages to YOU:_____

☐ Phone number for detailed voice mail to YOU:_____

☐ E-mail address that may be used to send information to your AUTHORIZED INDIVIDUAL:_____

☐ Phone number that may be used to text messages to your AUTHORIZED INDIVIDUAL:_____

☐ Phone number for detailed voice mail to your AUTHORIZED INDIVIDUAL:_____

1. I understand that I may revoke these designations at any time by notifying the appropriate Yale University Department/Physician in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Yale University prior to their receipt of the revocation.
2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.
3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPAA.
4. I understand that this Authorization will: (***Must check one***)
   ( ) expire 1 year from the date executed: or
   ( ) be effective for the lifetime of the patient unless revoked (see #1 above)

**Name of Patient:** _____

**Signature of Patient/Personal Representative**: _____ **Relationship to Patient**_____ **Date:** _____

**Name of Personal Representative:**

***YOU MAY REFUSE TO SIGN THIS FORM***