Printed Name _____

Date of Birth _____

HAR # _____ *E#*_____

Bellin Health Communication Consent

I give permission for Bellin Health to communicate with the following person(s) regarding:

Name: SCHOOL NAME Relationship: SCHOOL STAFF Phone: SCHOOL PHONE #

- ☐ My billing and payment information
- ☐ Appointment management, including scheduling, cancelling and rescheduling of appointments
- ✓ Medical information, including diagnosis's, results and treatment plans

Name: EX. NAME (PARENT, GUARDIAN, GRANDPARENT) Relationship: EX. MOTHER, FATHER, ETC Phone: PHONE #

- ✓ My billing and payment information
- ✓ Appointment management, including scheduling, cancelling and rescheduling of appointments
- ✓ Medical information, including diagnosis's, results and treatment plans

Name: EX. NAME (PARENT, GUARDIAN, GRANDPARENT) Relationship: EX. MOTHER, FATHER, ETC Phone: PHONE #

- ✓ My billing and payment information
- ✓ Appointment management, including scheduling, cancelling and rescheduling of appointments
- ✓ Medical information, including diagnosis's, results and treatment plans

- ☐ I decline any communication to others outside of myself or legal guardian(s).

These communications may occur when the identified person(s) joins me at my visit, or communicates for me by telephone, e-mail, or other electronic method.

I give permission to Bellin Health Systems to contact me on my cell phone, home and/or work phone using prerecorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by e-mail, text messaging, or by any other form of electronic communication, based on my communication preferences. Standard messaging rates may apply.

This disclosure form is in effect until changed or revoked by me. Only I can change who is named on this form to communicate with Bellin Health about my health 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 the release of copies of my medical records requires a specific authorization form signed by myself or my legal representative.

Signature: _____

Date: _____

(Patient or person legally authorized to sign for patient)

Printed Name: _____