Consent Forms

Saint Luke's Health System

Protected Health Information – Communication Preferences

Please communicate preferences about my health care with me in the following manner: (Check all that apply.)

- ☐ My home telephone number is:_____
  - ☐ Ok to leave a message with detailed information
  - ☐ Ok to leave a message with call-back information only
- ☐ My work telephone number is:_____
  - ☐ Ok to leave a message with detailed information
  - ☐ Ok to leave a message with call-back information only
- ☐ My cellular telephone number is:_____
  - ☐ Ok to leave a message with detailed information
  - ☐ Ok to leave a message with call-back information only
- ☐ Written communication
  - ☐ Ok to mail to my home address: _____
    _____
  - ☐ Ok to mail to my work/office: _____
    _____
- ☐ MySaintLuke's patient portal

Check applicable box:

☐ I was offered and made available, but I am electing not to receive a copy of SLHS Notice of Privacy Practices.

☐ I acknowledge receiving a copy of SLHS Notice of Privacy Practices.

You may discuss detailed information about my healthcare needs with the following individual(s):

Name of individual	Telephone number	Relationship to patient
1._____	_____	_____
2._____	_____	_____

Patient name:_____ Birthdate:_____ Patient Account #:_____

You will be asked to review and update your preferences on a yearly basis. You may change your preferences or withdraw permission for the individuals indicated above at any time by contacting your Saint Luke's provider. Your communication preferences applies to all providers and facilities within Saint Luke's Health System.

Note: These preferences do not apply to behavioral health visits.

_____/_____/_____

Signature of patient or personal representative* Date Time

*If signed by a personal representative, the following information must also be included:
Name of personal representative and description of their authority to act on behalf of patient: _____
_____
_____

Patient Label: