SSM Health
Sharing Health Information
Communication Preferences

Please Print: _____
Patient First Name **MI** **Last Name** **Date of Birth**

Please complete all, and CIRCLE the patient's first communication choice:

Relationship to Patient (Circle): Self Parent Guardian If other, please specify_____

Contact 1: Cell (_____) _____- _____ Home (_____) _____- _____ Work (_____) _____- _____

Contact 2: Cell (_____) _____- _____ Home (_____) _____- _____ Work (_____) _____- _____

Communication Preferences (Please circle below)

Leave a detailed message?	NA	Cell	Home	Work
Leave a message with call back number only?	NA	Cell	Home	Work
Send a message through MyChart?	Yes	No		

Other communication preferences_____

Unless the patient objects, SSM Health may share or discuss information about the patient with a caregiver or someone who helps pay for the patient's care (friend or family member). The patient's provider will determine what information about them needs to be shared based on a need-to-know basis.

Please identify all persons who are involved in the patient's care or payment that we may share health information with:

Name	Relationship	Phone Number

I, the patient/ parent or legal guardian permit the staff at SSM Medical Group to discuss my/my child's protected health information, by communications selected above, with the person(s) named above. This includes the ability to make, cancel, or reschedule appointments on the patient's behalf and assist in making payments or inquiring about the patient's billing account.

In addition, the patient's health information may be shared if:

- **You are present and do not object to sharing the information with others who are with you.**
- **You give your provider or plan permission to share the information.**
- **You are not present, and the provider determines based on professional judgment that it is in the patient's best interest.**

We will follow the above information unless notified by the patient in writing. This document does not apply to the disclosure of specific mental health care information and other sensitive information governed by HIPAA and the MO Mental Health Code and Confidentiality Act.

Signature of Patient/Parent or Legal Guardian **Date**

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Complete the below section ONLY if the patient is under 18 years of age or has a POA/legal guardian. Please identify all person(s) who have authorization to make appointments, bring the patient to SSM Health for medical care, and consent to medical treatment.

Name	Relationship	Phone Number

In addition, in the event of an emergency or non-emergency situation requiring medical treatment, I hereby grant permission for any and all medical and/or dental attention to be administered to the patient, in the event of accident or illness. This permission includes but is not limited to the administration of first aid, ambulance care/transportation, or other care as deemed necessary by a medical provider.

This Sharing Health Information form is valid for one year from its completion date unless otherwise renewed or updated.

Signature of Patient/Parent or Legal Guardian **Date**

(Pediatric patients please see back of form)