Northwestern Memorial® Hospital

Patient Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information; please complete the following which tells us how you wish to be contacted.

I wish to be contacted in the following manner (check all that apply):

- ❑ Home Telephone Number _____
  - ❑ Do not contact me at home
  - ❑ Leave message with department/office name and call-back number on answering machine
  - ❑ Leave message with medical information on answering machine
  - ❑ Give information to family member(s)

- ❑ Work Telephone Number _____
  - ❑ Do not contact me at work
  - ❑ Leave message with department/office name and call-back number on voicemail
  - ❑ Leave message with medical information on voicemail
  - ❑ Communicate medical information to co-workers/assistant

- ❑ Written Communication
  - ❑ Do not send written medical information to me
  - ❑ Mail information to my home address on file
  - ❑ Mail to my work/office address on file
  - ❑ Mail information to other address: List _____
  - ❑ Fax to the following number _____

- ❑ E-Mail Communication
  - ❑ I do not want to communicate by E-mail
  - ❑ You can communicate via E-mail with me at _____
    Patient Authorization Form on the reverse side must also be signed

Our office will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form. By your signature below, you agree to be communicated in the above manner.

Patient Signature _____ Date _____

PATIENT AUTHORIZATION TO USE E-MAIL
FOR COMMUNICATION OF CLINICAL INFORMATION

I hereby authorize Northwestern Memorial Hospital (including any affiliates, subsidiaries, and any entities in which Northwestern Memorial Hospital or its affiliates of subsidiaries has an interest) (collectively, "NM") to utilize electronic mail to communicate clinical information to me pertaining to health care services that have been rendered to me ("E-Mail"). I acknowledge and understand that such E-Mail may contain personal and private medical information of mine including, but not limited to, my name, address, social security number, date of birth, race and ethnicity demographics, mother's maiden name, types and dates of health care services received, name and address of the provider administering each health care services, insurance coverage information and/or test results (the "Medical Records").

I acknowledge and understand that, although NM may engage in certain practices in order to protect the privacy of the contents of any E-Mail sent to me and will take all reasonable measures to protect my privacy, the E-Mail messages sent to me are not encrypted and travel over the Internet and, as a result, there is a risk that the E-Mail will be intercepted and read by third parties to whom the E-Mail is not directed. In authorizing NM to send me E-Mail, I assume the foregoing risk.

I understand that E-Mail is not an appropriate medium for conveying information relating to urgent or emergency medical matters and that I will use the telephone as my means of communication with NM or any other appropriate health care provider as the situation may warrant.

I understand that, by authorizing NM to send me E-Mail, certain employees and agents of NM may have access to my e-mail address and E-Mail content, such as triage nurses, consulting physicians and other health care providers that are permitted access to my medical records.

I acknowledge that I, and not NM, am responsible for the security of E-Mail communications sent from or stored on my computer or information system, including, but not limited to, protecting access to any E-Mail stored my computer or information system, implementing security measures when delivering E-Mail from my computer or information system and implementing virus protection on my computer or information system.

I hereby authorize NM to retain my e-mail address in its databases so that it may send me future communications regarding its services, fund raising activities and other matters relating to NM's business. I understand that I may revoke this authorization at any time by providing written notice, electronically or otherwise to Gwen McNatt, Manager of Transplant Clinic, at 675 N. St. Clair, Suite 1720, Chicago, Illinois, 60611. I acknowledge that NM will only use my e-mail address for NM business purposes and that it will not sell, transfer or otherwise disclose my e-mail address or any of my other personal information to any third parties without my prior consent.

I understand that my decision to permit NM is voluntary, and that treatment is not conditioned upon my election to do so.

I understand that I may revoke this authorization at any time by providing written notice, electronically or otherwise, to NM's Transplant Clinic.

I understand and agree not to hold NM liable for any damages resulting from their use of E-Mail in accordance with the terms of this authorization or the failure in any manner of any Northwestern Memorial information systems used to facilitate the delivery of such E-Mail.

English is my primary spoken and written language and I fully understand the meaning of this authorization.

A photostatic or facsimile copy of this authorization is valid as the original.

Print Name _____

Patient Signature _____

Date _____