Patient Communication Authorization

IUPUI Campus Health (CH) is allowed to contact you by telephone but need your written permission to use other types of communication. CH requests your permission to contact you by text or email with information regarding your health care and to web-enable you to use our patient portal. CH has enabled a portal for your use to securely perform the following: view lab results, vaccination information, make appointments, and communicate via email. An email is sent to you upon activation of the portal. Email sent through the University’s email system is secure but the portal has additional security measures.

Security of email sent from outside the University system or by text messages are not secure and there is a risk that the messages could be intercepted and read by someone other than yourself. Therefore, we request to use your University email address. IUPUI CH will not send you emails outside the University system. If you want to use texting, we require your authorization to do so.

To revoke this authorization, you must do so in writing and deliver the document to IUPUI CH. Alternatively, complete the Revoke Communication Authorize form and return to the IUPUI CH.

Please print your initials in the blank lines, complete any requested information and sign and date the form. If you do not wish to give permission, leave the line blank and/or strike though the line. This form is valid for one year.

_____ I give my permission for the clinic to web-enable me to use the patient portal

_____ I authorize IUPUI Campus Health to contact me by:
□ Text message at _______ - _______ - _______

□ Email ____________________________@iupui.edu __@iu.edu or @indiana.edu (Please circle your email domain).
An email message is sent to you after you are web-enabled.

_____ I authorize IUPUI Campus Health to leave messages on the home or cell phone voicemail.

_____ I authorize IUPUI Campus Health to communicate with the individuals listed below regarding my health care information. This may include test results, diagnosis, recommendations and referrals.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to you</th>
<th>Telephone Number</th>
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_____ I understand I have the right to revoke this consent at any time.

Patient signature ____________________ Printed name ____________________ Date ____________